Calendar No. 562

103D CONGRESS
2D SESSION

S. 2374

A BILL

To improve the United States private health care delivery system and Federal health care programs, to control health care costs, to guarantee access to health insurance coverage for all Americans, and for other purposes.

AUGUST 11, 1994

Read the second time and placed on the calendar

Calendar No. 562

103D CONGRESS
2D SESSION

S. 2374

To improve the United States private health care delivery system and Federal health care programs, to control health care costs, to guarantee access to health insurance coverage for all Americans, and for other purposes.

IN THE SENATE OF THE UNITED STATES

AUGUST 9 (legislative day, AUGUST 8), 1994

Mr. DOLE (for himself and Mr. PACKWOOD) introduced the following bill; which was read the first time

AUGUST 11, 1994

Read the second time and placed on the calendar

A BILL

To improve the United States private health care delivery system and Federal health care programs, to control health care costs, to guarantee access to health insurance coverage for all Americans, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

TITLE I—AFFORDABLE HEALTH INSURANCE COVERAGE

Subtitle A—Tax Incentives

SEC. 100. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this subtitle an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

PART I—EQUITABLE TAX TREATMENT OF INDIVIDUALS PROVIDING OWN HEALTH CARE

SEC. 101. DEDUCTION FOR INDIVIDUALS AND SELF-EMPLOYED INDIVIDUALS PROVIDING OWN HEALTH INSURANCE.

(a) GENERAL RULE.—Section 213 (relating to medical, dental, etc. expenses) is amended by adding at the end the following new subsection:

''(f) HEALTH INSURANCE COSTS OF INDIVIDUALS.—

''(1) IN GENERAL.—The adjusted gross income limitation under subsection (a) shall not apply to amounts paid by an individual during the taxable year for qualified health insurance costs (and such amounts shall not be taken into account in deter-

mining whether such limitation applies to other amounts).

''(2) QUALIFIED HEALTH INSURANCE COSTS.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'qualified health insurance costs' means amounts paid for insurance described in subsection (d)(1)(D)(i) for the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 152).

''(B) LIMITATIONS.—For purposes of subparagraph (A)—

''(i) NO DEDUCTION FOR EMPLOYER-SUBSIDIZED HEALTH COSTS.—Qualified health insurance costs shall not include any amount paid for insurance coverage of an individual for any month if the individual is eligible to participate for such month in an employer-subsidized health plan maintained by any employer of the taxpayer, the taxpayer's spouse, or any dependent.

''(ii) PHASE-IN.—In the case of taxable years beginning after 1993 and before 2000, only the following percentages of the

qualified health insurance costs shall be taken into account:

"If the taxable year begins in:	The applicable percentage is:
1994 or 1995	25 percent
1996 or 1997	50 percent
1998 or 1999	75 percent.

''(3) DEDUCTION NOT ALLOWED FOR SELF-EMPLOYMENT TAX PURPOSES.—The deduction allowable by reason of this subsection shall not be taken into account in determining an individual's net earnings from self-employment (within the meaning of section 1402(a)) for purposes of chapter 2.''

(b) DEDUCTION ALLOWED AGAINST GROSS INCOME.—Section 62(a) (defining adjusted gross income) is amended by inserting after paragraph (15) the following new paragraph:

''(16) DEDUCTION FOR HEALTH INSURANCE PREMIUMS.—The deduction allowed under section 213(a) for amounts described in section 213(f).''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1993.

PART II—MEDICAL SAVINGS ACCOUNTS

SEC. 111. DEDUCTION FOR CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 (relating to additional itemized deductions for indi-

viduals) is amended by redesignating section 220 as section 221 and by inserting after section 219 the following new section:

"SEC. 220. CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.

''(a) DEDUCTION ALLOWED.—In the case of an eligible individual, there shall be allowed as a deduction the amounts paid in cash during the taxable year by such individual to a medical savings account for the benefit of such individual or for the benefit of any spouse or dependent of such individual who is an eligible individual.

''(b) LIMITATIONS.—

''(1) ONLY 1 ACCOUNT PER FAMILY.—Except as provided in regulations prescribed by the Secretary, no deduction shall be allowed under subsection (a) for amounts paid to any medical savings account for the benefit of an individual, such individual's spouse, or any dependent of such individual if such individual, spouse, or dependent is a beneficiary of any other medical savings account.

''(2) DOLLAR LIMITATION.—

''(A) IN GENERAL.—The amount allowable as a deduction under subsection (a) with respect to any individual for the taxable year shall not exceed the lesser of—

''(i) $2,000 ($4,000 in the case of a medical savings account established on behalf of more than 1 individual), or

''(ii) the high deductible health plan differential.

In the case of a married individual filing a separate return, clause (i) shall be applied by substituting '$1,000' for '$2,000' and '$2,000' for '$4,000'.

''(B) HIGH DEDUCTIBLE HEALTH PLAN DIFFERENTIAL.—For purposes of subparagraph (A)(ii), the high deductible health plan differential with respect to any individual is the amount by which the cost of the high deductible health plan in which the individual is enrolled is less than the cost of the health plan providing the FedMed benefit package (within the meaning of section 21115(b) of the Social Security Act).

''(3) PHASE-IN OF DEDUCTION.—In the case of taxable years beginning after December 31, 1994, and before January 1, 2000, only the following percentages of the deduction allowable under this section (without regard to this paragraph) shall be allowed:

"If the taxable year begins in:	**The applicable percentage is:**
1995	25 percent

"If the taxable year begins in:	The applicable percentage is:
1996 or 1997	50 percent
1998 or 1999	75 percent.

''(c) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

''(1) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means any individual—

''(A) who is covered under a high deductible health plan during any portion of the calendar year with or within which the taxable year begins, and

''(B) who is not eligible during such calendar year—

''(i) to participate in an employer-subsidized health plan maintained by an employer of the individual, the individual's spouse, or any dependent of either, or

''(ii) to receive any employer contribution to a medical savings account.

For purposes of subparagraph (B), a self-employed individual (within the meaning of section 401(c)) shall not be treated as his own employer.

''(2) HIGH DEDUCTIBLE HEALTH PLAN.—The term 'high deductible health plan' means a health plan which has—

''(A) a deductible for each individual covered by the plan which is not less than $1,000, and

''(B) a family deductible which is not less than $2,000.

''(3) MEDICAL SAVINGS ACCOUNT.—The term 'medical savings account' has the meaning given such term by section 7705.

''(4) TIME WHEN CONTRIBUTIONS DEEMED MADE.—A contribution shall be deemed to be made on the last day of the preceding taxable year if the contribution is made on account of such taxable year and is made not later than the time prescribed by law for filing the return for such taxable year (not including extensions thereof).''

(b) DEDUCTION ALLOWED AGAINST GROSS INCOME.—Subsection (a) of section 62 (defining adjusted gross income), as amended by section 101, is amended by inserting after paragraph (16) the following new paragraph:

''(17) MEDICAL SAVINGS ACCOUNTS.—The deduction allowed by section 220.''

(c) CLERICAL AMENDMENT.—The table of sections for part VII of subchapter B of chapter 1 is amended by striking the last item and inserting the following new item:

''Sec. 220. Contributions to medical savings accounts.''

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1994.

SEC. 112. EXCLUSION FROM INCOME OF EMPLOYER CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Section 106 (relating to contributions by employers to accident and health plans) is amended by adding at the end the following new subsection:

''(b) CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

''(1) TREATMENT OF CONTRIBUTIONS.—

''(A) IN GENERAL.—Gross income of an employee who is covered by a high deductible health plan of an employer shall not include any employer contribution to a medical savings account on behalf of the employee or the employee's spouse or dependents.

''(B) NO CONSTRUCTIVE RECEIPT.—No amount shall be included in the gross income of any employee solely because the employee may choose between the contributions described in subparagraph (A) and employer contributions to a health plan of the employer.

''(2) DOLLAR LIMITATION.—The amount which may be excluded under paragraph (1) for any taxable year shall not exceed the lesser of—

''(A) $2,000 ($4,000 in the case of a medical savings account established on behalf of more than one individual), or

''(B) the high deductible health plan differential.

''(3) HIGH DEDUCTIBLE HEALTH PLAN DIFFERENTIAL.—For purposes of paragraph (2)(B), the high deductible health plan differential with respect to any employee is the amount by which the cost of the high deductible health plan in which the employee is enrolled is less than—

''(A) the cost of the health plan (for the same class of enrollment) which—

''(i) the employee is eligible to enroll in through the employer, and

''(ii) has the highest cost of all health plans in which the employee may enroll in through the employer, or

''(B) if the employee is not eligible to enroll in any such health plan through the employer, the cost of the health plan providing the FedMed benefit package.

''(4) DEFINITIONS.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'FedMed benefit package' has the meaning given such term by section 21115(b) of the Social Security Act.

''(B) HIGH DEDUCTIBLE HEALTH PLAN.—The term 'high deductible health plan' has the meaning given such term by section 220(c)(2).

''(C) MEDICAL SAVINGS ACCOUNT.—The term 'medical savings account' has the meaning given such term by section 7705.''

(b) EMPLOYER PAYMENTS EXCLUDED FROM EMPLOYMENT TAX BASE.—

(1) SOCIAL SECURITY TAXES.—

(A) Subsection (a) of section 3121 is amended by striking ''or'' at the end of paragraph (20), by striking the period at the end of paragraph (21) and inserting ''; or'', and by inserting after paragraph (21) the following new paragraph:

''(22) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able

to exclude such payment from income under section 106(b).''

(B) Subsection (a) of section 209 of the Social Security Act is amended by striking ''or'' at the end of paragraph (18), by striking the period at the end of paragraph (19) and inserting ''; or'', and by inserting after paragraph (19) the following new paragraph:

''(20) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b) of the Internal Revenue Code of 1986.''

(2) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 is amended by adding at the end the following new paragraph:

''(10) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS.—The term 'compensation' shall not include any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b).''

(3) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 is amended by striking ''or'' at the end

of paragraph (15), by striking the period at the end of paragraph (16) and inserting ''; or'', and by inserting after paragraph (16) the following new paragraph:

''(17) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b).''

(4) WITHHOLDING TAX.—Subsection (a) of section 3401 is amended by striking ''or'' at the end of paragraph (19), by striking the period at the end of paragraph (20) and inserting ''; or'', and by inserting after paragraph (20) the following new paragraph:

''(21) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b).''

(c) CONFORMING AMENDMENT.—Section 106 is amended by striking ''Gross'' and inserting:

''(a) GENERAL RULE.—Gross''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1994.

SEC. 113. MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Chapter 79 is amended by adding at the end the following new section:

"SEC. 7705. MEDICAL SAVINGS ACCOUNTS.

''(a) GENERAL RULE.—The term 'medical savings account' means a trust created or organized in the United States for the exclusive benefit of the beneficiaries of the trust, but only if the written governing instrument creating the trust meets the following requirements:

''(1) Except in the case of a rollover contribution described in subsection (c)(4), no contribution will be accepted unless—

''(A) it is in cash, and

''(B) it is made for a period during which the individual on whose behalf it is made is covered under a high deductible health plan.

''(2) Contributions will not be accepted for any calendar year in excess of $2,000 ($4,000 in the case of an account established on behalf of the individual and the individual's spouse and dependents).

''(3) The trustee is a bank (as defined in section 408(n)), insurance company (as defined in sec-

tion 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

''(4) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

''(5) No part of the trust assets will be invested in life insurance contracts.

''(6) The interest of an individual in the balance in the individual's account is nonforfeitable.

''(b) TAX TREATMENT OF ACCOUNTS.—

''(1) ACCOUNT TAXED AS GRANTOR TRUST.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the account beneficiary of a medical savings account shall be treated for purposes of this title as the owner of such account and shall be subject to tax thereon in accordance with subpart E of part I of subchapter J of this chapter (relating to grantors and others treated as substantial owners).

''(B) TREATMENT OF CAPITAL LOSSES.—With respect to assets held in a medical savings account, any capital loss for a taxable year from the sale or exchange of such an asset shall

be allowed only to the extent of capital gains from such assets for such taxable year. Any capital loss which is disallowed under the preceding sentence shall be treated as a capital loss from the sale or exchange of such an asset in the next taxable year.

''(2) ACCOUNT TERMINATES IF INDIVIDUAL ENGAGES IN PROHIBITED TRANSACTION.—

''(A) IN GENERAL.—If, during any taxable year of the account beneficiary, such beneficiary engages in any transaction prohibited by section 4975 with respect to the account, the account shall cease to be a medical savings account as of the first day of such taxable year.

''(B) ACCOUNT TREATED AS DISTRIBUTING ALL ITS ASSETS.—In any case in which any account ceases to be a medical savings account by reason of subparagraph (A) on the first day of any taxable year, subsection (c) shall be applied as if—

''(i) there were a distribution on such first day in an amount equal to the fair market value (on such first day) of all assets in the account (on such first day), and

''(ii) no portion of such distribution were used to pay qualified medical expenses.

''(3) EFFECT OF PLEDGING ACCOUNT AS SECURITY.—If, during any taxable year, the account beneficiary uses the account or any portion thereof as security for a loan, the portion so used is treated as distributed and not used to pay qualified medical expenses.

''(c) TAX TREATMENT OF DISTRIBUTIONS.—

''(1) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—Any amount paid or distributed out of a medical savings account which is not used exclusively to pay the qualified medical expenses of the account beneficiary or of the spouse or dependents of such beneficiary shall be included in the gross income of such beneficiary to the extent such amount does not exceed the excess of—

''(i) the aggregate contributions to such account which were not includible in gross income by reason of section 106(b) or which were deductible under section 220, over

''(ii) the aggregate prior payments or distributions from such account which were includible in gross income under this paragraph.

''(B) SPECIAL RULES.—For purposes of subparagraph (A)—

''(i) all payments and distributions during any taxable year shall be treated as 1 distribution, and

''(ii) any distribution of property shall be taken into account at its fair market value on the date of the distribution.

''(2) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—Paragraph (1) shall not apply to the distribution of any contribution paid during a taxable year to a medical savings account to the extent that such contribution exceeds the amount under subsection (a)(2) if—

''(A) such distribution is received by the individual on or before the last day prescribed by law (including extensions of time) for filing such individual's return for such taxable year, and

''(B) such distribution is accompanied by the amount of net income attributable to such excess contribution.

Any net income described in subparagraph (B) shall be included in the gross income of the individual for the taxable year in which it is received.

''(3) PENALTY FOR DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—The tax imposed by chapter 1 on the account beneficiary for any taxable year in which there is a payment or distribution from a medical savings account of such beneficiary which is includible in gross income under paragraph (1) shall be increased by 10 percent of the amount which is so includible.

''(B) EXCEPTION FOR DISABILITY OR DEATH.—Subparagraph (A) shall not apply if the payment or distribution is made after the account beneficiary becomes disabled within the meaning of section 72(m)(7) or dies.

''(C) EXCEPTION FOR DISTRIBUTIONS AFTER AGE 59½.—Subparagraph (A) shall not apply to any payment or distribution after the date on which the account beneficiary attains age 59½.

''(4) ROLLOVER CONTRIBUTION.—An amount is described in this paragraph as a rollover contribution if it meets the requirements of subparagraphs (A) and (B).

''(A) IN GENERAL.—Paragraph (1) shall not apply to any amount paid or distributed from a medical savings account to the account beneficiary to the extent the amount received is paid into a medical savings account for the benefit of such beneficiary not later than the 60th day after the day on which the beneficiary receives the payment or distribution.

''(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a medical savings account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a medical savings account which was not includible in the individual's gross income because of the application of this paragraph.

''(5) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of section 213, any payment or distribution out of a medical savings ac-

count for qualified medical expenses shall not be treated as an expense paid for medical care to the extent of the amount of such payment or distribution which is excludable from gross income solely by reason of paragraph (1)(A).

''(6) TRANSFER OF ACCOUNT INCIDENT TO DIVORCE.—The transfer of an individual's interest in a medical savings account to an individual's spouse or former spouse under a divorce or separation instrument described in subparagraph (A) of section 71(b)(2) shall not be considered a taxable transfer made by such individual notwithstanding any other provision of this subtitle, and such interest at the time of the transfer shall be treated as a medical savings account of such spouse, and not of such individual. Any such account or annuity shall, for purposes of this subtitle, be treated as maintained for the benefit of the spouse to whom the interest was transferred.

''(d) DEFINITIONS.—For purposes of this section—

''(1) QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—The term 'qualified medical expenses' means any expense—

''(i) for medical care (as defined in section 213(d)), or

''(ii) for qualified long-term care services (as defined in section 213(g)).

''(B) EXCEPTION FOR INSURANCE.—

''(i) IN GENERAL.—Such term shall not include any expense for insurance.

''(ii) EXCEPTIONS.—Clause (i) shall not apply to any expense for—

''(I) coverage under a qualified long-term care contract (as defined in section 7702B(b)),

''(II) coverage under a health plan during a period of continuation coverage described in section 4980B(f)(2)(B),

''(III) coverage under a medicare supplemental policy (as defined in section 1882(g)(1) of the Social Security Act), or

''(IV) payment of premiums under part A or B of title XVIII of the Social Security Act.

''(2) ACCOUNT BENEFICIARY.—The term 'account beneficiary' means the individual for whose benefit the medical savings account is maintained.

''(e) CUSTODIAL ACCOUNTS.—For purposes of this section, a custodial account shall be treated as a trust if—

''(1) the assets of such account are held by a bank (as defined in section 408(n)), insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the account will be consistent with the requirements of this section, and

''(2) the custodial account would, except for the fact that it is not a trust, constitute a medical savings account described in subsection (a).

For purposes of this title, in the case of a custodial account treated as a trust by reason of the preceding sentence, the custodian of such account shall be treated as the trustee thereof.

''(f) REPORTS.—The trustee of a medical savings account shall make such reports regarding such account to the Secretary and to the individual for whose benefit the account is maintained with respect to contributions, distributions, and such other matters as the Secretary may require under regulations. The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by those regulations.''

(b) TAX ON EXCESS CONTRIBUTIONS.—Section 4973 (relating to tax on excess contributions to individual retirement accounts, certain section 403(b) contracts, and certain individual retirement annuities) is amended—

(1) by inserting ''**MEDICAL SAVINGS ACCOUNTS,**'' after ''**ACCOUNTS,**'' in the heading of such section,

(2) by striking ''or'' at the end of paragraph (1) of subsection (a),

(3) by redesignating paragraph (2) of subsection (a) as paragraph (3) and by inserting after paragraph (1) the following:

''(2) a medical savings account (within the meaning of section 7705(a)), or'', and

(4) by adding at the end the following new subsection:

''(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—For purposes of this section, in the case of a medical savings account (within the meaning of section 7705(a)), the term 'excess contributions' means the amount by which the amount contributed for the taxable year to the account exceeds the amount which may be contributed to the account under section 7705(a)(2) for such taxable year. For purposes of this subsection, any contribution which is distributed out of the medical savings

account in a distribution to which section 7705(c)(2) applies shall be treated as an amount not contributed.''

(c) TAX ON PROHIBITED TRANSACTIONS.—Section 4975 (relating to prohibited transactions) is amended—

(1) by adding at the end of subsection (c) the following new paragraph:

''(4) SPECIAL RULE FOR MEDICAL SAVINGS ACCOUNTS.—An individual for whose benefit a medical savings account (within the meaning of section 7705(a)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a medical savings account by reason of the application of section 7705(b)(2)(A) to such account.'', and

(2) by inserting ''or a medical savings account described in section 7705(a)'' in subsection (e)(1) after ''described in section 408(a)''.

(d) FAILURE TO PROVIDE REPORTS ON MEDICAL SAVINGS ACCOUNTS.—Section 6693 (relating to failure to provide reports on individual retirement accounts or annuities) is amended—

(1) by inserting ''**OR ON MEDICAL SAVINGS ACCOUNTS**'' after ''**ANNUITIES**'' in the heading of such section, and

(2) by adding at the end of subsection (a) the following: ''The person required by section 7705(f) to file a report regarding a medical savings account at the time and in the manner required by such section shall pay a penalty of $50 for each failure unless it is shown that such failure is due to reasonable cause.''

(e) CLERICAL AMENDMENTS.—

(1) The table of sections for chapter 43 is amended by striking the item relating to section 4973 and inserting the following:

> ''Sec. 4973. Tax on excess contributions to individual retirement accounts, medical savings accounts, certain 403(b) contracts, and certain individual retirement annuities.''

(2) The table of sections for subchapter B of chapter 68 is amended by inserting ''or on medical savings accounts'' after ''annuities'' in the item relating to section 6693.

Subtitle B—Premium Assistance

SEC. 121. PREMIUM ASSISTANCE.

(a) MEDICAID STATE PLAN REQUIREMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 201(a), is amended—

(1) by striking ''and'' at the end of paragraph (62);

(2) by striking the period at the end of paragraph (63) and inserting ''; and''; and

(3) by adding at the end the following new paragraph:

''(64) provide for a State program furnishing premium assistance in accordance with part B.''.

(b) STATE PROGRAMS FOR PREMIUM ASSISTANCE.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by adding at the end the following new part:

''PART B—STATE PROGRAMS FOR PREMIUM ASSISTANCE

''Subpart 1—Establishment of Premium Assistance Programs

''SEC. 1951. REQUIREMENT TO OPERATE STATE PROGRAM.

''(a) IN GENERAL.—A State with a State plan approved under part A shall have in effect a program for furnishing premium assistance under section 1952 to families with incomes below certain income thresholds in calendar years beginning after 1996.

''(b) DESIGNATION OF STATE AGENCY.—A State may designate any appropriate State agency to administer the program under this part.

"SEC. 1952. ASSISTANCE WITH CERTIFIED HEALTH PLAN PREMIUMS.

''(a) ELIGIBILITY.—

''(1) IN GENERAL.—A family (as defined in section 1957(4)) which has been determined by a State under section 1953 to be a premium subsidy eligible family (as defined in paragraph (2)) shall be entitled to premium assistance in the amount determined under subsection (b).

''(2) PREMIUM SUBSIDY ELIGIBLE FAMILY.—

''(A) IN GENERAL.—For purposes of this part, the term 'premium subsidy eligible family' means a family which has a family income determined under section 1957(2) which does not exceed 150 percent of the poverty line (as defined in section 1957(5)).

''(B) REDUCTION IN ELIGIBILITY PERCENTAGE.—For requirement that the President reduce the percentage of the poverty line applicable to family income under subparagraph (A), see subpart 2.

''(b) AMOUNT OF ASSISTANCE.—

''(1) IN GENERAL.—Except as provided in paragraph (4), the amount of premium assistance for a month for a premium subsidy eligible family is the lesser of—

''(A) the subsidy percentage specified in paragraph (3) multiplied by 1/12th of the annual premium for coverage under the certified health plan in which the family is enrolled, or

''(B) the subsidy percentage specified in paragraph (3) multiplied by 1/12th of the maximum subsidy amount for the year for the family (determined under paragraph (2)).

''(2) MAXIMUM SUBSIDY AMOUNT.—

''(A) IN GENERAL.—The maximum subsidy amount determined under this paragraph for a year for a family is the maximum subscription charge for the family's class of enrollment under all health benefits plans offered under chapter 89 of title 5, United States Code for the year, as adjusted under subparagraph (B).

''(B) ADJUSTMENTS.—The Secretary shall adjust the maximum subscription charge for a family determined under subparagraph (A) by the age adjustment factors specified under section 21114(b)(2)(C) and for geographic differences in health care costs based on the community rating area in which the family resides.

''(3) SUBSIDY PERCENTAGE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'subsidy percentage' means—

''(i) 100 percent if the family income does not exceed 100 percent of the poverty line;

''(ii) 90 percent if the family income exceeds 100 percent of the poverty line but does not exceed 110 percent of the poverty line;

''(iii) 80 percent if the family income exceeds 110 percent of the poverty line but does not exceed 115 percent of the poverty line;

''(iv) 70 percent if the family income exceeds 115 percent of the poverty line but does not exceed 125 percent of the poverty line;

''(v) 60 percent if the family income exceeds 120 percent of the poverty line but does not exceed 125 percent of the poverty line;

''(vi) 50 percent if the family income exceeds 125 percent of the poverty line but

does not exceed 130 percent of the poverty line;

''(vii) 40 percent if the family income exceeds 130 percent of the poverty line but does not exceed 135 percent of the poverty line;

''(viii) 30 percent if the family income exceeds 135 percent of the poverty line but does not exceed 140 percent of the poverty line;

''(ix) 20 percent if the family income exceeds 140 percent of the poverty line but does not exceed 145 percent of the poverty line; and

''(x) 10 percent if the family income exceeds 145 percent of the poverty line but does not exceed 150 percent of the poverty line.

''(B) SPECIAL RULES.—

''(i) AFDC RECIPIENTS.—For a family receiving aid to families with dependent children under part A or E of title IV, the subsidy percentage shall be 100 percent.

''(ii) NON-CASH MEDICAID ELIGIBLES.—For a family that would have been

eligible for medical assistance under the State plan under part A under the eligibility rules in effect in the year preceding the first year the State began integrating individuals into the premium assistance program under this part in accordance with section 1932(a), the subsidy percentage shall be 100 percent.

''(C) REDUCTION IN SUBSIDY PERCENTAGE.—For requirement that the President reduce the subsidy percentages under subparagraph (A), see subpart 2.

''(c) PAYMENTS.—

''(1) IN GENERAL.—The amount of the premium assistance available to a premium subsidy eligible family under subsection (b) shall be paid by the State directly to the certified health plan in which the family is enrolled. Payments under the preceding sentence shall commence in the first month during which the family is enrolled in a certified health plan and determined under section 1953 to be a premium subsidy eligible family.

''(2) ADMINISTRATIVE ERRORS.—A State is financially responsible for premium assistance paid based on an eligibility determination error to the ex-

tent the State's error rate for eligibility determinations exceeds a maximum permissible error rate to be specified by the Secretary.

"SEC. 1953. ELIGIBILITY DETERMINATIONS.

''(a) IN GENERAL.—The Secretary shall promulgate regulations specifying requirements for State programs under this part with respect to determining eligibility for premium assistance, including requirements with respect to—

''(1) application procedures;

''(2) information verification procedures;

''(3) timeliness of eligibility determinations;

''(4) procedures for applicants to appeal adverse decisions; and

''(5) any other matters determined appropriate by the Secretary.

''(b) SPECIFICATIONS FOR REGULATIONS.—The regulations promulgated by the Secretary under subsection (a) shall include the following requirements:

''(1) APPLICATIONS.—A State program shall provide that a family may file an application for assistance with an agency designated by the State at any time, in person or by mail.

''(2) APPLICATION FORM.—A State program shall provide for the use of an application form developed by the Secretary under subsection (c).

''(3) DISTRIBUTION OF APPLICATIONS.—A State program shall make available applications for assistance through employers and appropriate public agencies or organizations.

''(4) DISTRIBUTION OF INFORMATION ON CERTIFIED HEALTH PLANS.—A State program shall provide that each family applying for assistance under this part receives the information determined appropriate by the Secretary on each certified health plan providing the FedMed benefits package as described in section 21115(b) offered in the community rating area in which the family resides.

''(5) REQUIREMENT TO SUBMIT REVISED APPLICATION.—A State program shall, in accordance with regulations promulgated by the Secretary, require families to submit revised applications during a year to reflect increases in estimated family incomes during the year. The State shall revise the amount of any premium assistance based on such a revised application.

''(6) AFDC APPLICANTS.—A State program shall include a procedure under which families ap-

plying for benefits under title IV shall have an opportunity to apply for assistance under this part in connection with such application.

''(7) VERIFICATION.—A State program shall provide for verification of the information supplied in applications under this part.

''(c) ADMINISTRATION OF STATE PROGRAMS.—

''(1) IN GENERAL.—The Secretary shall establish standards for States operating programs under this part which ensure that such programs are operated in a uniform manner with respect to application procedures, data processing systems, and such other administrative activities as the Secretary determines to be necessary.

''(2) APPLICATION FORMS.—The Secretary shall develop a standard application form for assistance which shall—

''(A) be simple in form and understandable to the average individual;

''(B) require the provision of information necessary to make a determination as to whether a family is a premium subsidy eligible family including a declaration of estimated income by the family based, at the election of the family—

''(i) on multiplying by a factor of 4 the family's family income for the 3-month period immediately preceding the month in which the application is made, or

''(ii) on estimated income for the entire year for which the application is submitted; and

''(C) require attachment of such documentation as deemed necessary by the Secretary in order to ensure eligibility for assistance.

''(d) EFFECTIVENESS OF ELIGIBILITY FOR PREMIUM SUBSIDIES.—A determination by a State that a family is a premium subsidy eligible family shall be effective for the calendar year for which such determination is made unless a revised application submitted under subsection (b)(5) indicates that a family is no longer eligible for premium assistance.

"SEC. 1954. END-OF-YEAR RECONCILIATION FOR PREMIUM ASSISTANCE.

''(a) IN GENERAL.—

''(1) REQUIREMENT TO FILE STATEMENT.—A family which received premium assistance under this part from a State for any month in a calendar year shall file with the State an income reconciliation

statement to verify the family's family income for the year. Such a statement shall be filed at such time, and contain such information, as the State may specify in accordance with regulations promulgated by the Secretary.

''(2) NOTICE OF REQUIREMENT.—A State shall provide a written notice of the requirement under paragraph (1) at the time a family submits an application for premium assistance under this part and at the end of the year to a family which received such assistance from such State in any month during the year.

''(b) RECONCILIATION OF PREMIUM ASSISTANCE BASED ON ACTUAL INCOME.—

''(1) IN GENERAL.—Based on and using the income reported in the reconciliation statement filed under subsection (a) with respect to a family, the State shall compute the amount of premium assistance that should have been provided under this part with respect to the family for the year involved.

''(2) OVERPAYMENT OF ASSISTANCE.—If the total amount of the premium assistance provided was greater than the amount computed under paragraph (1), the family is liable to the State to pay an amount equal to the amount of the excess payment.

Any amount collected by a State under this paragraph shall be submitted to the Secretary in a timely manner.

''(3) STATE OPTION.—A State may, in accordance with regulations promulgated by the Secretary, establish a procedure under which any overpayments of premium assistance determined under paragraph (2) with respect to a family for a year may be collected or paid, as appropriate, through adjustments to the premium assistance furnished to such family in the succeeding year.

''(c) VERIFICATION.—Each State may use such information as it has available to verify income of families with applications filed under this part.

''(d) PENALTIES FOR FAILURE TO FILE.—In the case of a family which is required to file a statement under this section in a year who fails to file such a statement by such date as the Secretary shall specify in regulations, the entire amount of the premium assistance provided in such year shall be considered an excess amount under subsection (b)(2) and such family shall not be eligible for premium assistance under this part until such statement is filed. A State, using rules established by the Secretary, shall waive the application of this subsection if the family establishes, to the satisfaction of the State under such

rules, good cause for the failure to file the statement on a timely basis.

"SEC. 1955. PENALTIES FOR MATERIAL MISREPRESENTATION AND FALSE INFORMATION.

''(a) IN GENERAL.—Any individual who knowingly makes a material misrepresentation of information or provides false information in an application for assistance under this part under section 1953 or an income reconciliation statement under section 1954 shall be liable to the Federal Government for the amount any premium assistance received by the individual on the basis of such misrepresentation or false information and interest on such amount at a rate specified by the Secretary, and shall, in addition, be liable to the Federal Government for $2,000 or, if greater, 3 times the amount of any premium assistance received by the individual on the basis of such misrepresentation or false information.

''(b) COLLECTION OF PENALTY AMOUNTS.—A State which receives an application for assistance or an income reconciliation statement with respect to which a material misrepresentation has been made or false information has been provided shall collect the penalty amount required under subsection (a) and submit 50 percent of such amount to the Secretary in a timely manner.

"SEC. 1956. PAYMENTS TO STATES.

''(a) IN GENERAL.—

''(1) PAYMENTS FOR PREMIUM ASSISTANCE.—A State operating a program for furnishing premium assistance under this part shall be entitled to receive payments in an amount equal to the amount of premium assistance paid on behalf of premium subsidy eligible families. Such payments shall be made at such time and in such form as provided in regulations promulgated by the Secretary.

''(2) MATCHING PAYMENTS FOR ADMINISTRATIVE EXPENSES.—The Secretary shall pay to each State operating a program for furnishing premium assistance under this part, for each quarter beginning with the quarter commencing January 1, 1997, an amount equal to 50 percent of the total amount expended by the State during the quarter as found necessary by the Secretary for the proper and efficient administration of the program.

''(3) STATE ENTITLEMENT.—This subsection constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Government to provide payments to States operating programs under this part in accordance with this subsection.

''(b) FUNDING.—The amount paid to States under subsection (a) shall be paid by the Secretary from out of any funds in the Treasury of the United States not otherwise appropriated.

''(c) AUDITS.—The Secretary shall conduct regular audits of the activities under the State programs conducted under this part.

"SEC. 1957. DEFINITIONS AND DETERMINATIONS OF INCOME.

''For purposes of this part:

''(1) CERTIFIED HEALTH PLAN.—The term 'certified health plan' means a certified health plan (within the meaning of section 21003(b)) providing the FedMed benefits package as described in section 21115(b).

''(2) DETERMINATIONS OF INCOME.—

''(A) IN GENERAL.—The term 'income' means adjusted gross income (as defined in section 62(a) of the Internal Revenue Code of 1986)—

''(i) determined without regard to sections 135, 162(l), 911, 931, and 933 of such Code; and

''(ii) increased by—

''(I) the amount of interest received or accrued which is exempt from tax, plus

''(II) the amount of social security benefits (described in section 86(d) of such Code) which is not includible in gross income under section 86 of such Code.

''(B) FAMILY INCOME.—The term 'family income' means, with respect to a family, the sum of the income for all members of the family, not including the income of a dependent child with respect to which no return is required under the Internal Revenue Code of 1986.

''(3) ELIGIBLE INDIVIDUAL.—

''(A) IN GENERAL.—The term 'eligible individual' means an individual who is residing in the United States and who is—

''(i) a citizen or national of the United States; or

''(ii) a lawful alien (as defined in subparagraph (C)).

''(B) EXCLUSIONS.—The term 'eligible individual' shall not include—

''(i) an individual who is eligible for medical assistance under part A consisting of acute medical services described in section 1931(b)(1);

''(ii) an individual who is entitled to benefits under part A of title XVIII;

''(iii) an individual with respect to whom an employer contribution toward the premium for coverage under the certified health plan in which the individual is enrolled is paid (or offered to be paid) on behalf of such individual; and

''(iv) an individual who is an inmate of a public institution (except as a patient of a medical institution).

''(C) LAWFUL ALIEN.—The term 'lawful alien' means an individual who is—

''(i) an alien lawfully admitted for permanent residence,

''(ii) an asylee,

''(iii) a refugee,

''(iv) an alien whose deportation has been withheld under section 243(h) of the Immigration and Nationality Act, or

''(v) a parolee who has been paroled for a period of 1 year or more.

''(4) FAMILY.—The term 'family'—

''(A) means, with respect to an eligible individual who is not a child, the individual; and

''(B) includes the following persons (if any):

''(i) The individual's spouse if the spouse is an eligible individual.

''(ii) The individual's children (and, if applicable, the children of the individual's spouse) if they are eligible individuals.

''(5) POVERTY LINE.—The term 'poverty line' means the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) that—

''(A) in the case of a family of less than five individuals, is applicable to a family of the size involved; and

''(B) in the case of a family of more than four individuals, is applicable to a family of four persons.

"Subpart 2—Deficit Neutral Spending on Premium Assistance

"SEC. 1960. ENSURING DEFICIT NEUTRAL SPENDING ON PREMIUM ASSISTANCE.

''(a) LIMITATION ON PREMIUM ASSISTANCE SPENDING.—In each fiscal year (beginning with 1996), spending for premium assistance shall be limited to the excess of—

''(1) the aggregate limitation described in subsection (b), over

''(2) mandatory expenditures under title XVIII and part A of XIX, including any offsetting receipts required under title XVIII but excluding any discretionary expenditures under such title or part A of title XIX.

''(b) AGGREGATE LIMITATION.—

''(1) IN GENERAL.—For purposes of this section the aggregate limitation shall be—

''(A) for fiscal year 1996, $282 billion

''(B) for fiscal year 1997, $311 billion

''(C) for fiscal year 1998, $341 billion

''(D) for fiscal year 1999, $381 billion

''(E) for fiscal year 2000, $421 billion

''(F) for fiscal year 2001, $466 billion

''(G) for fiscal year 2002, $518 billion

''(H) for fiscal year 2003, $576 billion

''(I) for fiscal year 2004, $640 billion; and

''(J) for fiscal year 2005 and succeeding fiscal years, the amount in the preceding fiscal year increased by the growth in the per capita Gross Domestic Product.

''(2) ADJUSTMENT BASED ON MID-SESSION REVIEW OF ESTIMATES.—If it is determined under the mid-session review of estimates under subsection (d) that expenditures under the provisions of title XVIII, part A of title XIX, and the premium assistance program under subpart 1 for the preceding fiscal year exceeded the estimates for such fiscal year then the amount under paragraph (1) for the upcoming fiscal year shall be decreased by the amount of such excess.

''(c) PRESIDENT'S BUDGET TO INCLUDE PREMIUM ASSISTANCE ESTIMATES.—

''(1) IN GENERAL.—When the President submits a budget (as required by section 1105 of title 31), the President shall include in such budget—

''(A) estimates of expenditures under the provisions of title XVIII, part A of title XIX, and the premium assistance program under subpart 1 otherwise provided under such provisions without regard to this section; and

''(B) a comparison of the total of such expenditures with the aggregate limitation established under subsection (b); and

''(C) estimates of the income eligibility amount (described in subsection (d)(1)) and subsidy percentages (described in subsection (d)(3)) under the premium assistance program that are necessary to comply with enforcement of the limitation on premium assistance spending under subsection (d).

''(2) FISCAL YEARS COVERED.—The President shall submit such estimates for the upcoming fiscal year and the following 4 fiscal years beginning with the budget submitted for fiscal year 1996, and

''(A) beginning with the budget for fiscal year 1997, the current fiscal year; and

''(B) beginning with the budget for fiscal year 1998, the current fiscal year and the preceding fiscal year.

''(d) ENFORCING THE LIMITATION ON PREMIUM ASSISTANCE SPENDING.—

''(1) MID-SESSION REVIEW ESTIMATES.—As part the President's supplemental summary providing revised estimates of the budget (commonly called the 'mid-session review of the budget'), the Presi-

dent shall issue estimates of expenditures under title XVIII, part A of XIX, and the premium assistance program under subpart 1 otherwise provided without regard to this section for—

''(A) the upcoming fiscal year;

''(B) the current fiscal year (beginning with the mid-session review for the fiscal year 1997 budget); and

''(C) the preceding fiscal year (beginning with the mid-session review for the fiscal year 1998 budget).

''(2) MAXIMUM INCOME ELIGIBILITY.—Based on the estimates provided pursuant to paragraph (1), the Director of the Office of Management and Budget (referred to in this section as the ''Director'') shall, after consultation with the Secretary, determine the maximum income amount (expressed as a percentage of the poverty line (as defined in section 1957(5))) under which families may be eligible for premium assistance in the next calendar year such that spending for premium assistance in the upcoming fiscal year does not exceed the limitation established under subsection (b), except that the Director shall not establish a maximum income amount

for the next calendar year that is below such amount for the current calendar year.

''(3) OTHER MODIFICATIONS.—If maintaining the maximum income amount at the level that applies in the current calendar year in the next calendar year would cause spending to exceed the limitation for premium assistance in the upcoming fiscal year, the Director shall order a uniform percentage reduction in the subsidy percentages specified under section 1952(a)(3) to ensure spending does not exceed the limitation.''.

(c) CONFORMING AMENDMENTS.—(1) Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by striking the title and inserting the following:

"TITLE XIX—MEDICAL ASSISTANCE PROGRAMS AND STATE PROGRAMS FOR PREMIUM ASSISTANCE

"PART A—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS".

(2) Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by striking each reference to ''this title'' and inserting ''this part''.

TITLE II—HEALTH INSURANCE AND DELIVERY SYSTEMS REFORM

Subtitle A—Federal Standards for State Certification Programs

SEC. 201. STATE PLAN FOR CERTIFICATION OF HEALTH INSURANCE AND DELIVERY SYSTEMS.

(a) MEDICAID STATE PLAN REQUIREMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by striking ''and'' at the end of paragraph (61), by striking the period at the end of paragraph (62) and inserting ''; and'', and by inserting after paragraph (62) the following new paragraph:

''(63) provide that the State is a participating State under title XXI.''

(b) PARTICIPATING STATE PLAN FOR CERTIFICATION OF HEALTH INSURANCE AND DELIVERY SYSTEMS.—The Social Security Act is amended by adding at the end the following new title:

''TITLE XXI—STATE PLAN FOR CERTIFICATION OF HEALTH INSURANCE AND DELIVERY SYSTEMS

''TABLE OF CONTENTS

''Subtitle A—Participating State Program

''PART I—GENERAL RESPONSIBILITIES

''SEC. 21001. ESTABLISHMENT OF PARTICIPATING STATE PROGRAMS.

''A State shall be a participating State for purposes of this title if such State establishes by not later than January 1, 1998, a certification and consumer value program (in this title referred to as a 'State program') to carry out participating State responsibilities specified in this title.

''SEC. 21002. ACCESS TO STANDARDIZED HEALTH CARE COVERAGE.

''(a) ACCESS TO STANDARDIZED COVERAGE.—

''(1) IN GENERAL.—Except as provided in paragraph (2), a State program shall require that each insured health plan issued, sold, offered for sale, or operated in the State shall be certified by the appropriate certifying authority as a certified health plan.

''(2) FEDERAL CERTIFICATION OF SELF-INSURED PLANS.—In the case of self-insured health plans, the Secretary of Labor shall carry out activities under this title in the same manner as a participating State would carry out such activities with respect to an insured health plan subject to this title.

''(b) ACCESS TO AFFORDABLE COVERAGE.—A State program shall require the following:

''(1) COMMUNITY RATING.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), all health plans shall be community-rated health plans which cover only community-rated individuals.

''(B) EXPERIENCE-RATED HEALTH PLANS.—Subparagraph (A) shall not apply to any health plan which—

''(i) is a self-insured health plan of an experience-rated employer, or

''(ii) is an insured health plan which is experience-rated,

but any such plan may cover only experience-rated individuals.

''(2) SUBSIDIZED COVERAGE.—Individuals shall be entitled to such premium assistance as is provided under the program described in part B of title XIX.

''(c) ACCESS THROUGH HEALTH PLAN SPONSORS.—Subject to the requirements of part II of subtitle B—

''(1) a State program shall require each health plan sponsor to make available to each community-rated individual the opportunity to enroll, directly or through a purchasing cooperative, in a certified health plan which provides the FedMed benefits package established under section 21115(b); and

''(2) each health plan sponsor may offer any other certified health plan which provides any other health benefits package, including a supplemental benefit package to the FedMed benefits package, but may not require an individual or group to purchase supplemental coverage or link the pricing of the FedMed benefits package to the purchase of a supplemental benefits package.

''SEC. 21003. GENERAL DEFINITIONS RELATING TO HEALTH PLANS.

''(a) HEALTH PLAN.—For purposes of this title—

''(1) IN GENERAL.—The term 'health plan' means any plan or arrangement which provides, or pays the cost of, health benefits. Such term does not include the following, or any combination thereof:

''(A) Coverage only for accidental death, dismemberment, dental, or vision.

''(B) Coverage providing wages or payments in lieu of wages for any period during which the employee is absent from work on account of sickness or injury.

''(C) A medicare supplemental policy (as defined in section 1882(g)(1)).

''(D) Coverage issued as a supplement to liability insurance.

''(E) Worker's compensation or similar insurance.

''(F) Automobile medical-payment insurance.

''(G) A long-term care insurance policy, including a nursing home fixed indemnity policy (unless the Secretary determines that such a policy provides sufficiently comprehensive coverage of a benefit so that it should be treated as a health plan).

''(H) An equivalent health care program.

''(I) Any plan or arrangement not described in any preceding subparagraph which provides for benefit payments, on a periodic basis, for a specified disease or illness or period of hospitalization without regard to the costs incurred or services rendered during the period to which the payments relate.

''(J) Such other plan or arrangement as the Secretary determines is not a health plan.

''(2) INSURED HEALTH PLAN.—

''(A) IN GENERAL.—The term 'insured health plan' means any health plan which is a hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract offered by an insurer.

''(B) INSURER.—The term 'insurer' means—

''(i) a licensed insurance company,

''(ii) a prepaid hospital or medical service plan,

''(iii) a health maintenance organization, or

''(iv) any other similar entity,

which is engaged in the business of providing a plan of health insurance or health benefits or services.

''(3) SELF-INSURED HEALTH PLAN.—The term 'self-insured health plan' means an employee welfare benefit plan, church plan, government plan, or other arrangement which—

''(A) provides health benefits funded in a manner other than through the purchase of one or more insured health plans, but

''(B) does not include any coverage or insurance described in subparagraphs (A) through (J) of paragraph (1).

''(b) CERTIFIED HEALTH PLAN.—For purposes of this title, the term 'certified health plan' means a health plan which is certified by the appropriate certifying authority as meeting the applicable requirements of this title.

''(c) TERMS AND RULES RELATING TO COMMUNITY AND EXPERIENCE RATING.—For purposes of this title—

''(1) COMMUNITY-RATED HEALTH PLAN.—The term 'community-rated health plan' means a health plan which meets the requirements of section 21114.

''(2) COMMUNITY-RATED INDIVIDUAL.—The term 'community-rated individual' means an individual—

''(A) who is not an experience-rated individual, or

''(B) who is an experience-rated individual (determined without regard to this subparagraph) and whose employer does not provide an employer-subsidized certified health plan.

Such term includes the spouse and dependents of such individual.

''(3) EXPERIENCE-RATED INDIVIDUAL.—The term 'experience-rated individual' means an individual who is an employee of an experience-rated employer. Such term includes the spouse and dependents of such individual.

''(4) EXPERIENCE-RATED EMPLOYER.—

''(A) IN GENERAL.—The term 'experience-rated employer' means—

''(i) in the case of a self-insured health plan, any employer, and

''(ii) in the case of an insured health plan, with respect to any calendar year, any employer if, on each of 20 days during the preceding calendar year (each day being in a different week), such employer (or any predecessor) employed more than 50 employees for some portion of the day.

''(B) CERTAIN OTHER PLANS.—Such term shall include multiemployer plans, church association plans, and rural electric cooperative or rural telephone cooperative association plans.

''(5) SPECIAL RULE FOR SPOUSES AND DEPENDENTS.—If any individual is offered coverage under a health plan as the spouse or a dependent of a primary enrollee of such plan, such individual shall have the status of such enrollee unless such individual is eligible to elect other coverage and so elects.

"PART II—CERTIFICATION AND CONSUMER VALUE

"SEC. 21011. CERTIFICATION OF HEALTH PLANS.

''(a) IN GENERAL.—Each State program shall provide for the certification of health plans as certified health plans in accordance with the insurance reform standards and the delivery system guidelines established by the Secretary under subtitle B.

''(b) USE OF PRIVATE ENTITIES.—

''(1) EXPERTS.—A State shall consult with experts in designing and implementing a State certification program under this section.

''(2) ACCREDITATION.—A State program may provide for the use of private accreditation entities

in carrying out all or part of the duties under subsection (a).

''(c) COORDINATION OF ACTIVITIES.—In designing and implementing the State certification program under this section, a State shall coordinate activities by State public health offices with activities of the insurance commissioner of the State, and with other relevant State agencies, with respect to the duties and responsibilities of each such entity.

''(d) CERTIFICATION FEES.—A State program may impose appropriate certification fees on health plans seeking certification.

''(e) CERTIFICATION ENFORCEMENT.—A State program shall provide for the monitoring and enforcement of the certification of health plans.

"**SEC. 21012. CONSUMER VALUE PROGRAM.**

''(a) ESTABLISHMENT OF PROGRAM.—Each State, in accordance with minimum guidelines established by the Secretary under section 21103, shall establish and operate a consumer value program to provide consumers in the State with comparative value information on the performance of all health plans in each community rating area in the State. State consumer value programs under this section may exceed the guidelines established by the Secretary.

''(b) USE OF PRIVATE ORGANIZATIONS.—A State may operate the consumer value program through a contract with a private organization selected by the State.

''(c) ELIGIBILITY FOR GRANTS.—Each State with a consumer value program shall be eligible for grants under section 21103(b). To be eligible for such a grant, a State shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(d) ADDITIONAL REQUIREMENTS.—Each State program shall meet the requirements specified under subtitles B and C of title XI with respect to certified health plans.

"SEC. 21013. ESTABLISHMENT OF COMMUNITY RATING AREAS.

''(a) ESTABLISHMENT.—Each participating State under the State program shall, by not later than January 1, 1998, provide for the inclusion of all areas of the State into 1 or more community rating areas. The program may revise the boundaries of such areas from time to time consistent with this section.

''(b) MULTIPLE AREAS.—With respect to a community rating area—

''(1) no metropolitan statistical area or primary metropolitan statistical area in a State may be di-

vided into more than 1 community rating area in such State;

''(2) the number of individuals residing within a community rating area may not be less than 250,000; and

''(3) no area incorporated into a community rating area may be incorporated into another community rating area.

''(c) BOUNDARIES.—In establishing boundaries for community rating areas, a participating State may not discriminate on the basis of, or otherwise take into account, disability, health status, or perceived need for health services of a particular population. Such restrictions shall not prohibit participating States from establishing such boundaries to ensure that underserved and vulnerable populations are better served.

''(d) INTERSTATE AREAS.—Two or more contiguous participating States may provide for the establishment of a community rating area that includes adjoining areas of the States so long as all areas of any metropolitan statistical area or primary metropolitan statistical area within such States are within the same community rating area.

''SEC. 21014. RISK ADJUSTMENT PROGRAMS.

''Each participating State under the State program shall provide a risk adjustment program meeting the

standards developed by the Secretary under section 21104.

''SEC. 21015. SPECIFICATION OF INITIAL GENERAL ENROLLMENT PERIOD.

''Upon the date of the commencement of the State program, the participating State shall specify for the State (or for each community rating area) an initial period, of not less than 90 days, during which individuals in the State (or area) may enroll in certified health plans.

''PART III—TREATMENT OF CERTAIN STATE LAWS

''SEC. 21021. PREEMPTION OF CERTAIN STATE LAW RESTRICTIONS ON HEALTH PLANS.

''Effective as of January 1, 1996—

''(1) a State may not prohibit or limit a health plan from including incentives for enrollees to use the services of participating providers;

''(2) a State may not prohibit or limit a health plan from requiring enrollees to obtain care from participating providers;

''(3) a State may not prohibit or limit a health plan from requiring enrollees to obtain referrals for specialty treatment;

''(4) a State may not prohibit or limit the establishment of different payment rates for participating and non-participating providers;

''(5) a State may not prohibit or limit a health plan from limiting the number and types of participating providers;

''(6) a State may not prohibit or limit a health plan from using single source suppliers for pharmacy services, medical equipment, and other supplies and services; and

''(7) a State may not prohibit or limit the corporate practice of medicine.

''SEC. 21022. PREEMPTION FROM STATE BENEFIT MANDATES.

''Effective as of January 1, 1996, no State shall establish or enforce any law or regulation that requires any certified health plan to cover any specific item or service.

''SEC. 21023. PREEMPTION OF STATE LAW REGULATING UTILIZATION MANAGEMENT AND REVIEW.

''Effective as of January 1, 1996, a State may not regulate utilization management and review programs of any health plan to the extent not provided by this title.

"SEC. 21024. STATE LAWS REGARDING END OF LIFE TREATMENT.

''Nothing in this title shall be construed to invalidate any State law that has the effect of preventing involuntary denial of lifesaving medical treatment when such denial would cause the involuntary death of the patient pending transfer of the patient to a health care provider willing to provide such treatment.

"PART IV—DEFINITIONS AND RULES

"SEC. 21100. DEFINITIONS AND RULES OF GENERAL APPLICATION.

''Except as otherwise specifically provided, in this title the following definitions and rules apply:

''(1) APPROPRIATE CERTIFYING AUTHORITY.—The term 'appropriate certifying authority' means—

''(A) except as provided in subparagraph (B), in the case of an insured health plan, the State commissioner or superintendent of insurance or other State authority in the participating State; or

''(B) in the case of a self-insured health plan, the Secretary of Labor.

''(2) CHURCH ASSOCIATION PLAN.—The term 'church association plan' means a church plan (as defined in section 414(e) of the Internal Revenue Code of 1986).

''(3) DELIVERY SYSTEM.—The term 'delivery system' with respect to a health plan includes a fee-for-service, use of preferred providers, staff or group model health maintenance organizations, and such other arrangements as the Secretary may recognize.

''(4) DEPENDENT.—The term 'dependent' means, with respect to any individual, any person—

''(A) who is a child or stepchild of the individual; and

''(B) who is—

''(i) under 22 years of age (under 25 years of age in the case of a fulltime student) and unmarried, or

''(ii) permanently and totally disabled (within the meaning of section 151(c)(5)(C) of such Code).

''(5) EMPLOYER, EMPLOYEE, AND EMPLOYMENT DEFINED.—

''(A) IN GENERAL.—Except as otherwise provided in this subtitle—

''(i) the term 'employment' has the meaning given such term under section 3121 of the Internal Revenue Code of 1986,

''(ii) the term 'employee' has the meaning given such term under section 3121 of such Code, subject to the provisions of chapter 25 of such Code, and

''(iii) the term 'employer' has the same meaning as the term ''employer'' as used in such section 3121.

''(B) EXCEPTIONS.—For purposes of subparagraph (A)—

''(i) EMPLOYMENT.—

''(I) EMPLOYMENT INCLUDED.—Paragraphs (1), (2), (5), (7) (other than clauses (i) through (iv) of subparagraph (C) and clauses (i) through (v) of subparagraph (F)), (8), (9), (10), (11), (13), (15), (18), and (19) of section 3121(b) of the Internal Revenue Code of 1986 shall not apply.

''(II) EXCLUSION OF SEASONAL OR TEMPORARY.—Employment shall not include seasonal or temporary services performed for an employer for less than 6 months in a calendar year.

''(ii) EMPLOYEES.—

''(I) TREATMENT OF SELF-EMPLOYED.—The term 'employee' includes a self-employed individual.

''(II) EXCLUSION OF CERTAIN FOREIGN EMPLOYMENT.—The term 'employee' does not include an individual with respect to service, if the individual is not a citizen or resident of the United States and the service is performed outside the United States.

''(C) AGGREGATION RULES FOR EMPLOYERS.—For purposes of this title—

''(i) all employers treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 shall be treated as a single employer, and

''(ii) under regulations of the Secretary of the Treasury, all employees of organizations which are under common control with one or more organizations which are exempt from income tax under subtitle A of the Internal Revenue Code of 1986 shall be treated as employed by a single employer.

The regulations prescribed under clause (ii) shall be based on principles similar to the principles which apply to taxable organizations under clause (i).

''(6) EQUIVALENT HEALTH CARE PROGRAM.—The term 'equivalent health care program' means—

''(A) part A or part B of the medicare program under title XVIII of the Social Security Act,

''(B) the medicaid program under title XIX of the Social Security Act,

''(C) the health care program for active military personnel under title 10, United States Code,

''(D) the veterans health care program under chapter 17 of title 38, United States Code,

''(E) the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in section 1073(4) of title 10, United States Code, and

''(F) the Indian health service program under the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

''(7) FAMILY.—The term 'family' includes an individual, the individual's spouse, and the individual's dependents (if any), as defined in paragraph (4).

''(8) HEALTH PLAN SPONSOR.—The term 'health plan sponsor' means, with respect to—

''(A) an insured health plan, the insurer, and

''(B) a self-insured health plan, the experience-rated employer sponsor.

''(9) MULTIEMPLOYER PLAN.—The term 'multiemployer plan' has the meaning given such term in section 3(37) of the Employee Retirement Income Security Act of 1974, and includes any plan that is treated as such a plan under title I of such Act.

''(10) NAIC.—The term 'NAIC' means the National Association of Insurance Commissioners.

''(11) PARTICIPATING STATE.—The term 'participating State' means a State establishing a State program under this title.

''(12) PURCHASING COOPERATIVE.—The term 'purchasing cooperative' means a health insurance purchasing cooperative described in section 21201.

''(13) RURAL ELECTRIC COOPERATIVE.—The term 'rural electric cooperative' has the meaning

given such term in section 3(40)(A)(iv) of the Employee Retirement Income Security Act of 1974.

''(14) RURAL TELEPHONE COOPERATIVE ASSOCIATIONS.—The term 'rural telephone cooperative association' has the meaning given such term in section 3(40)(A)(v) of the Employee Retirement Income Security Act of 1974.

''(15) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services or the Secretary's delegate.

''(16) STATE.—The term 'State' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

"Subtitle B—Standards for Reform

"PART I—ESTABLISHMENT AND APPLICATION OF STANDARDS AND GUIDELINES

"SEC. 21101. INSURANCE REFORM STANDARDS.

''Except as provided in section 21105, the Secretary, in consultation with the NAIC, shall develop and publish specific standards and evaluation criteria to implement the insurance reform standards specified in part II by not later than 9 months after the date of the enactment of this title.

''SEC. 21102. DELIVERY SYSTEM GUIDELINES.

''(a) ESTABLISHMENT.—Except as provided in section 21105, not later than 9 months after the date of enactment of this title, the Secretary, in consultation with the NAIC and other organizations with expertise in the areas of quality assurance (including the Joint Commission on Accreditation of Health Care Organizations, the National Committee for Quality Assurance, and peer review organizations), shall establish minimum guidelines specified in part III for the certification of health plan delivery systems and the enforcement of such guidelines.

''(b) MINIMUM GUIDELINES.—Each participating State through the State program may exceed the guidelines established by the Secretary under this section.

''SEC. 21103. CONSUMER VALUE PROGRAM.

''(a) DEVELOPMENT OF GUIDELINES.—The Secretary shall develop and distribute to participating States model minimum guidelines for the establishment of State consumer value programs under section 21012. Such guidelines shall include a description of a consumer report card that is designed to standardize consumer information among all States concerning certified health plans.

''(b) GRANT PROGRAM.—The Secretary may award demonstration grants to States that establish consumer value programs, with priority given by the Secretary to

States that exceed the minimum guidelines established by the Secretary under this section.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out the purposes of this section.

"SEC. 21104. RISK ADJUSTMENT PROGRAMS.

''Except as provided in section 21105, the Secretary shall develop standards for participating States to provide risk adjustment programs for participation by community-rated insured health plans and reinsurers of self-insured health plans sponsored by employers which are not experience-rated employers as described in section 21116(b).

"SEC. 21105. STANDARDS AND GUIDELINES BY SECRETARY OF LABOR.

''The Secretary of Labor shall develop for self-insured health plans appropriate insurance reform standards and minimum delivery system guidelines similar to such standards and guidelines described in sections 21101 and 21102.

"SEC. 21106. GENERAL RULES.

''(a) CONSTRUCTION.—Whenever in this subtitle a requirement or standard is imposed on a health plan, the requirement or standard is deemed to have been imposed on the insurer or sponsor of the plan in relation to that plan.

''(b) USE OF INTERIM, FINAL REGULATIONS.—In order to permit the timely implementation of the provisions of this title, the Secretary and the Secretary of Labor are each authorized to issue regulations under this title on an interim basis that become final on the date of publication, subject to change based on subsequent public comment.

''(c) REFERENCE TO REFORM STANDARDS.—For purposes of this title, the term 'reform standards' means the standards developed under this subtitle and applicable under part II.

"PART II—INSURANCE REFORM STANDARDS APPLICABLE TO HEALTH PLANS

"SEC. 21111. GUARANTEED ISSUE AND RENEWAL.

''(a) ISSUE.—

''(1) IN GENERAL.—Except as otherwise provided in this section, a health plan sponsor—

''(A) offering a community-rated health plan shall offer such plan to any community-rated individual applying for coverage; and

''(B) offering an experience-rated health plan or a self-insured health plan shall offer such plan to any experience-rated individual eligible for coverage under the plan through the individual's experience-rated employer.

''(2) AVAILABILITY.—

''(A) IN GENERAL.—A community-rated health plan shall be made available throughout the entire community rating area in which such plan is offered, including through any purchasing cooperative choosing to offer such plan.

''(B) GEOGRAPHIC LIMITATIONS.—A community-rated health plan may deny coverage under the plan to a community-rated individual who resides outside the community rating area in which such plan is offered, but only if such denial is applied uniformly, without regard to health status or insurability of individuals.

''(C) APPLICABILITY TO NETWORK PLANS.—Subparagraphs (A) and (B) shall each be applied to a community-rated health plan using a staff or group model health maintenance organization or other network delivery system by substituting 'service area determined by the appropriate certifying authority' for 'community rating area'.

''(3) APPLICATION OF CAPACITY LIMITS.—

''(A) IN GENERAL.—Subject to subparagraph (B), an insured health plan may apply to

the appropriate certifying authority to cease enrolling individuals under the plan if—

''(i) the plan ceases to enroll any new individuals; and

''(ii) the plan can demonstrate to the applicable certifying authority that its financial or provider capacity to serve previously covered groups or individuals (and additional individuals who will be expected to enroll because of affiliation with such previously covered groups or individuals) will be impaired if it is required to enroll other individuals.

''(B) FIRST-COME-FIRST-SERVED.—An insured health plan is only eligible to exercise the limitations provided for in subparagraph (A) if such plan provides for enrollment of individuals on a first-come-first-served basis (except in the case of additional individuals described in subparagraph (A)(ii)).

''(b) RENEWAL.—

''(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), a health plan that is issued to an individual shall be renewed at the option of the individual.

''(2) GROUNDS FOR REFUSAL TO RENEW.—A health plan sponsor may refuse to renew, or may terminate, a health plan under this title only for—

''(A) nonpayment of premiums;

''(B) fraud on the part of the individual; or

''(C) misrepresentation of material facts on the part of the individual relating to an application for coverage or claim for benefits.

''(3) EXIT FROM MARKET.—

''(A) IN GENERAL.—An insurer shall renew an insured health plan through a particular type of delivery system (as defined in section 21100) with respect to a community-rated employer or community-rated individual, unless such insurer—

''(i) elects not to renew all of its insured health plans using such delivery system issued to all such employers and individuals in a State; and

''(ii) provides notice to the appropriate certifying authority and to each such employer and individual covered under the plan of such termination at least 180 days before the date of expiration of the plan.

''(B) PROHIBITION ON MARKET RE-ENTRY.—In the case of such a termination, such insurer may not provide for the issuance of any insured health plan using such a delivery system to a community-rated employer or community-rated individual in such State during the 5-year period beginning on the date of the termination of the last plan not so renewed.

''(c) CERTAIN EXCLUDED PLANS.—The provisions of this section, other than subsections (b) and (e)(2)(B), shall not apply to any religious fraternal benefit society in existence as of September 1993, which bears the risk of providing insurance to its members, and which is an organization described in section 501(c)(8) of the Internal Revenue Code of 1986 which is exempt from taxation under section 501(a) of such Code.

"**SEC. 21112. ENROLLMENT.**

''(a) ENROLLMENT PROCESS.—A health plan shall establish an enrollment process which consists of—

''(A) a general annual enrollment period of at least 30 days; and

''(B) special enrollment periods for changes in enrollment,

as specified by the reform standards, which shall include the circumstances under which such special en-

rollment periods are required and the duration of such periods.

''(b) COMMENCEMENT OF COVERAGE.—

''(1) WAITING PERIODS.—An insurer or an employer may impose a waiting period of not more than 30 days for coverage for a reasonable time necessary to process an enrollment.

''(2) NEWBORNS.—In the event of the birth or adoption of a child of an enrollee, coverage of such child under such enrollee's health plan (regardless of the class of enrollment) shall begin on the date of such birth or adoption and shall continue, in the absence of any enrollment of such child during a special enrollment period provided under subsection (a)(1)(C), for at least 45 days.

"SEC. 21113. NONDISCRIMINATION BASED ON HEALTH STATUS.

''(a) IN GENERAL.—Except as provided under subsection (b), a health plan may not—

''(1) deny, limit, or condition the coverage under (or benefits of) the plan; and

''(2) in the case of an experience-rated health plan, vary the premium,

based on the health status, medical condition, claims experience, receipt of health care, medical history, anticipated

need for health care expenses, disability, or lack of evidence of insurability, of an individual.

''(b) TREATMENT OF PREEXISTING CONDITION EXCLUSIONS FOR ALL SERVICES.—

''(1) IN GENERAL.—Subject to paragraph (4), a health plan may impose a limitation or exclusion of benefits relating to treatment of a condition based on the fact that the condition preexisted the effective date of the plan with respect to an individual enrolling as a member of a group only if—

''(A) the condition was diagnosed or treated during the 3-month period ending on the day before the date of enrollment under the plan;

''(B) the limitation or exclusion extends for a period not more than 6 months after the date of enrollment under the plan;

''(C) the limitation or exclusion does not apply to an individual who, as of the date of birth, was covered under the plan; or

''(D) the limitation or exclusion does not apply to pregnancy.

''(2) CREDITING OF PREVIOUS COVERAGE.—A health plan shall provide that if an individual under such plan is in a period of continuous coverage as of the date of enrollment under such plan, any pe-

riod of exclusion of coverage with respect to a preexisting condition shall be reduced by 1 month for each month in the period of continuous coverage.

''(3) DEFINITIONS.—As used in this subsection:

''(A) PERIOD OF CONTINUOUS COVERAGE.—The term 'period of continuous coverage' means the period beginning on the date an individual is enrolled under a certified health plan or an equivalent health care program and ends on the date the individual is not so enrolled for a continuous period of more than 3 months.

''(B) PREEXISTING CONDITION.—The term 'preexisting condition' means, with respect to coverage under a health plan, a condition which was diagnosed, or which was treated, within the 3-month period ending on the day before the date of enrollment (without regard to any waiting period).

''(4) SPECIAL RULES FOR INDIVIDUALS.—In the case of an individual who is not enrolling as a member of a group in a health plan—

''(A) any reference to 3 months in paragraph (1)(A) is deemed a reference to 6 months,

''(B) any reference to 6 months in paragraphs (1)(B) and (2) is deemed a reference to 12 months, and

''(C) any reference to 3-month period in paragraph (3)(B) is deemed a reference to 6-month period.

''(5) PROHIBITION ON PREEXISTING CONDITION EXCLUSION DURING AMNESTY PERIOD.—

''(A) IN GENERAL.—This subsection shall not apply during an initial enrollment period described in section 21015.

''(B) CAPACITY LIMITATION.—The participating State may establish a limit on the number of new enrollees a health plan must accept during the period described in subparagraph (A) based on the plan's share of the applicable community-rated or experience-rated population.

"SEC. 21114. RATING LIMITATIONS FOR COMMUNITY-RATED MARKET.

''(a) STANDARD PREMIUMS WITH RESPECT TO COMMUNITY-RATED INDIVIDUALS.—Each community-rated health plan shall establish within each community rating area in which the plan is to be offered a standard premium for individual enrollment for each benefits package of the

plan, including the FedMed benefits package established under section 21115(b).

''(b) UNIFORM PREMIUMS WITHIN COMMUNITY RATING AREAS.—

''(1) IN GENERAL.—Subject to paragraphs (2), (3), and (4), the standard premium for each package described in subsection (a) for all community-rated individuals within a community rating area shall be the same and shall not include the costs of premium processing, enrollment, and marketing that would vary depending on whether the method of enrollment is through a purchasing cooperative, or directly through a health plan sponsor, an employer, or a broker.

''(2) APPLICATION TO ENROLLEES.—

''(A) IN GENERAL.—The premium charged for coverage in a community-rated health plan shall be the product of—

''(i) the standard premium (established under paragraph (1));

''(ii) in the case of enrollment other than individual enrollment, the family adjustment factor specified under subparagraph (B); and

''(iii) the age adjustment factor (specified under subparagraph (C)).

''(B) FAMILY ADJUSTMENT FACTOR.—The reform standards shall specify family adjustment factors that reflect the relative actuarial costs of benefit packages based on family classes of enrollment (as compared with such costs for individual enrollment).

''(C) AGE ADJUSTMENT FACTOR.—The reform standards shall specify uniform age categories for age adjustment factors that reflect the relative actuarial costs of benefit packages among enrollees. For individuals who have attained age 18 but not age 65, the highest age adjustment factor may not exceed the lowest age adjustment factor by—

''(i) 4 times for the first 3 years beginning with the first year of certification by the appropriate certifying authority, and

(ii) 3 times for years thereafter.

''(3) ADMINISTRATIVE CHARGES.—

''(A) IN GENERAL.—In accordance with the reform standards, a community-rated health plan may add a separately-stated administrative

charge not to exceed 15 percent of the plan's premium which is based on identifiable differences in marketing and other legitimate administrative costs which vary by size of the enrolling group and method of enrollment, including enrollment directly through a health plan, an employer, or a broker (as defined in such standards).

''(B) APPLICATION.—The administrative charge for any plan described in subparagraph (A) shall be applied uniformly with respect to group size and method of enrollment.

''(4) DISCOUNTS.—In accordance with the reform standards, an insurer may allow premium discounts based on health promoting activities.

"**SEC. 21115. BENEFITS OFFERED.**

''(a) OFFERING OF PACKAGES INCLUDING FEDMED.—Subject to the requirements of section 21002(c), a health plan may offer, in addition to a FedMed benefits package, other benefits packages in a community rating area, if the rates for all such packages (including the FedMed) are based on the plan's total enrollment in the community-rated population in such area and the rating variations do not exceed the difference in

the actuarial value of the specific benefit variations for such population.

''(b) FEDMED BENEFITS PACKAGE DESCRIBED.—

''(1) IN GENERAL.—

''(A) PACKAGE DESCRIBED.—A FedMed benefits package described in this subsection is a benefits package that covers all of the items and services under the categories of health care items and services specified by the Secretary under paragraph (2) when medically necessary or appropriate (as determined in accordance with paragraph (3)) and provides for a cost-sharing schedule specified by the Secretary under paragraph (4).

''(B) ACTUARIAL VALUE.—

''(i) INITIAL PACKAGE.—For 1997, the FedMed benefits package established by the Secretary under this subsection that has the lowest actuarial value of all the FedMed benefits packages established by the Secretary under this subsection, shall have an actuarial value that equals the actuarial value of the benefits package provided under the health benefits plan offered under chapter 89 of title 5, United

States Code, during 1994 with the highest enrollment, adjusted for a national population under 65 years of age (as determined by the Secretary).

''(ii) SUCCEEDING YEARS.—For succeeding years, the FedMed benefits package established by the Secretary under this subsection that has the lowest actuarial value of all the FedMed benefits packages established by the Secretary under this subsection for the year, shall have an actuarial value that equals the actuarial value of the FedMed benefits package that has the lowest actuarial value of all the FedMed benefits packages that existed in the preceding year.

''(iii) DETERMINING ACTUARIAL VALUE.—For purposes of clause (ii), the Secretary shall use the same actuarial assumptions in determining the actuarial value of the FedMed benefits packages for the current and preceding years.

''(2) CATEGORIES OF HEALTH CARE ITEMS AND SERVICES.—

''(A) IN GENERAL.—The categories of health care items and services specified by the Secretary under this paragraph shall include at least the categories described in section 1302(1) of the Public Health Service Act and section 8904(a) of title 5, United States Code. The Secretary may add or delete categories of health care items and services under this paragraph as medical practice changes.

''(B) SPECIFYING ITEMS AND SERVICES.—

''(i) IN GENERAL.—The Secretary shall specify the items and services under the categories specified under subparagraph (A).

''(ii) PRIORITIES FOR THE SECRETARY.—In specifying items and services under this subparagraph the Secretary shall take into account the following:

''(I) MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES.—With respect to mental health and substance abuse services, the Secretary shall give priority to—

''(aa) parity for such services with other medical services

with respect to cost-sharing and duration of treatment;

''(bb) management for such services that ensures access to medically appropriate treatment; and

''(cc) encouraging the use of outpatient treatments to the greatest extent feasible.

''(II) VULNERABLE POPULATIONS AND UNDERSERVED AREAS.—The Secretary shall give priority to the needs of children and vulnerable populations, including those populations in rural, frontier, and underserved areas.

''(III) PREVENTION.—The Secretary shall give priority to improving the health of individuals through prevention.

''(3) MEDICAL NECESSITY OR APPROPRIATENESS.—

''(A) DETERMINATIONS BY HEALTH PLANS.—

''(i) IN GENERAL.—The determination of medical necessity or appropriateness of specific treatments or procedures shall be made by individual health plans with reference to criteria established under subparagraph (B).

''(ii) NEW PROCEDURES AND TECHNOLOGIES.—Health plans may make coverage decisions regarding new procedures and technologies with reference to the criteria established by the Secretary under subparagraph (B).

''(B) CRITERIA ESTABLISHED.—The Secretary shall establish general criteria for determining whether an item or service specified by the Secretary under paragraph (2)(B) is medically necessary or appropriate.

''(4) COST-SHARING.—The Secretary shall establish cost-sharing schedules to be provided by a FedMed benefits package. In establishing such cost-sharing schedules, the Secretary shall meet the following requirements:

''(A) ANNUAL BASIS.—The Secretary shall review and update cost-sharing schedules as de-

termined appropriate by the Secretary, but on at least an annual basis.

''(B) DELIVERY SYSTEMS.—

''(i) IN GENERAL.—In establishing cost-sharing schedules for FedMed benefits packages, the Secretary shall ensure that the schedules permit a variety of delivery systems, including fee-for-service, preferred provider organizations, point of service, and health maintenance organizations.

''(ii) INITIAL COST-SHARING SCHEDULES.—The cost-sharing schedules initially established by the Secretary shall meet the following requirements:

''(I) MODERATE COST-SHARING.—A moderate cost-sharing schedule shall be similar to the cost-sharing schedule under the health benefits plan offered under chapter 89 of title 5, United States Code, with the highest enrollment that uses a fee-for-service delivery system.

''(II) LOW COST-SHARING.—A low cost-sharing schedule shall be similar to the cost-sharing schedule

under the health benefits plan offered under chapter 89 of title 5, United States Code, with the highest enrollment that provides a health maintenance organization.

''(III) INTERMEDIATE COST-SHARING.—An intermediate cost-sharing schedule for a preferred provider system, point of service system, or similar system, shall encourage use of providers in the network by providing for higher cost-sharing for out-of-network, non-emergency services.

''(C) COST-SHARING RULES.—Cost-sharing schedules established by the Secretary may include copayments, coinsurance, deductibles, and out-of-pocket limits. The copayments, coinsurance, deductibles and out-of-pocket limits on cost-sharing for a year under the schedules shall be applied based upon expenses incurred for covered items and services furnished in the year.

''(c) LIFETIME LIMITATION PROHIBITED.—No health plan may impose a lifetime limitation on the provision of benefits.

"SEC. 21116. RISK ADJUSTMENT.

''(a) IN GENERAL.—Each community-rated health plan shall participate in a risk adjustment program of the State described in section 21014.

''(b) MANDATORY STOP-LOSS INSURANCE.—Each employer which is not an experience-rated employer and which sponsors a self-insured health plan shall carry stop-loss insurance purchased from a reinsurer regulated by the participating State.

"SEC. 21117. PROHIBITION OF DISCRIMINATION.

''(a) IN GENERAL.—No State, health plan, or health plan sponsor may discriminate in participation, reimbursement, or indemnification against a health care provider who is acting within the scope of the provider's license or certification under applicable State or Federal law solely on the basis of such license or certification of such provider.

''(b) NUMBER AND TYPE.—Nothing in this title shall—

''(1) prevent a health plan from matching the number and type of health care providers to the needs of the plan members; or

''(2) except as specifically provided in this title, establish any other measure designed to maintain quality or to control costs.

"PART III—MINIMUM DELIVERY SYSTEM GUIDELINES APPLICABLE TO HEALTH PLANS

"SEC. 21121. MINIMUM DELIVERY SYSTEM GUIDELINES.

''(a) IN GENERAL.—The minimum guidelines for the certification by a participating State of health plan delivery systems specified under this part are as follows:

''(1) Establishing and maintaining health plan quality assurance, including—

''(A) quality management;

''(B) credentialing;

''(C) utilization management;

''(D) governance;

''(E) plan and quality processes;

''(F) health care provider selection and due process in selection; and

''(G) practice guidelines and protocols.

''(2) Providing consumer protection for health plan enrollees, including—

''(A) comparative consumer information with respect to health plans in a form specified in subtitle B of title XI;

''(B) marketing agents and materials;

''(C) nondiscrimination in plan enrollment, disenrollment and service provision;

''(D) continuation of treatment with respect to health plans that become insolvent;

''(E) grievance procedures;

''(F) advanced directives; and

''(G) financial practices of health plans that interfere with quality of care.

''(3) Ensuring reasonable access to health care services, including—

''(A) ensuring that vulnerable populations have access to health care services, in accordance with the recommendations of the Prospective Payment Assessment Commission under subsection (c);

''(B) anti red-lining rules; and

''(C) prohibition on plan discrimination against health care providers (including discrimination solely on the basis of the academic degree of the provider).

''(4) Health plan financial standards, including—

''(A) plan solvency requirements;

''(B) financial standards relating to liquidity, accounting and reporting; and

''(C) guaranty fund participation.

''(b) CUSTOMIZED GUIDELINES.—In establishing guidelines under subsection (a), the Secretary shall rec-

ommend customized guidelines for the certification of different types of health plans, taking into consideration—

''(1) frontier, rural, and inner city factors; and

''(2) commercial insurance, managed-care plans, and delivery-system or provider-based plans.

''(c) ACCESS TO VULNERABLE POPULATIONS.—Not later than 1 year after the date of enactment of this title, the Prospective Payment Assessment Commission shall submit recommendations to the Secretary concerning guidelines under subsection (a)(3)(A). In preparing such recommendations, the Commission shall consider—

''(1) the anticipated impact of health care reform on access to health care services by individuals in vulnerable populations; and

''(2) safeguards needed to ensure the continued access to, and payment for, health care services provided to individuals in vulnerable populations.

''Subtitle C—Expanded Access to Health Plans

''PART I—ACCESS THROUGH HEALTH INSURANCE PURCHASING COOPERATIVES

''SEC. 21201. ESTABLISHMENT AND ORGANIZATION.

''(a) IN GENERAL.—Individual and small group market purchasing cooperatives (in this title referred to as 'purchasing cooperatives') may be established in accord-

ance with this part. Each purchasing cooperative shall be chartered under State law. An insurer may not form, underwrite, or possess a majority vote of a purchasing cooperative, but may administer such a cooperative.

''(b) DUTIES OF PURCHASING COOPERATIVES.—

''(1) IN GENERAL.—Subject to paragraph (2), each purchasing cooperative shall—

''(A) provide access to insured certified health plans to members throughout the entire community rating area served by the cooperative;

''(B) enter into agreements with insured certified health plans selected by the cooperative;

''(C) enter into agreements with community-rated employers located in the community rating area served by the cooperative;

''(D) enroll community-rated individuals in insured certified health plans; and

''(E) collect premiums from individuals enrolled in insured certified health plans through the purchasing cooperative and forward such premiums to the plans.

''(2) LIMITATION ON ACTIVITIES.—A purchasing cooperative shall not—

''(A) perform any activity (including review, approval, or enforcement) relating to payment rates for providers;

''(B) perform any activity (including certification or enforcement) relating to compliance of insured certified health plans with the requirements of part I or II of subtitle B; or

''(C) assume financial risk in relation to any such plan.

''(d) RULES OF CONSTRUCTION.—

''(1) ESTABLISHMENT NOT REQUIRED.—Nothing in this section shall be construed as requiring—

''(A) that a purchasing cooperative be established in each community rating area; and

''(B) that there be only one purchasing cooperative established with respect to a community rating area.

''(2) SINGLE ORGANIZATION SERVING MULTIPLE AREAS.—Nothing in this section shall be construed as preventing a single entity from being the purchasing cooperative for more than one community rating area.

"PART II—ACCESS THROUGH FEHBP

"SEC. 21211. SMALL BUSINESS PARTICIPATION IN FEHBP.

''For access by small businesses to health benefits plans offered by the Federal Employee Health Benefits Program, see chapter 90 of title 5, United States Code.

"PART III—ACCESS THROUGH ASSOCIATION PLANS

"Subpart A—Qualified Association Plans

"SEC. 21221. TREATMENT OF QUALIFIED ASSOCIATION PLANS.

''(a) GENERAL RULE.—For purposes of this title, in the case of a qualified association plan—

''(1) except as otherwise provided in this subpart, the plan shall meet all applicable requirements of this title for certified health plans offered by experience-rated employers,

''(2) if such plan is certified as meeting such requirements and the requirements of this subpart, such plan shall be treated as a plan established and maintained by an experience-rated employer which meets the requirements of this title for experience-rated plans, and individuals enrolled in such plan shall be treated as experience-rated individuals, and

''(3) any individual who is a member of the association not enrolling in the plan shall not be treat-

ed as an experience-rated individual solely by reason of membership in such association.

''(b) ELECTION TO BE TREATED AS PURCHASING COOPERATIVE.—Subsection (a) shall not apply to a qualified association plan if—

''(1) the health plan sponsor makes an irrevocable election to be treated as a purchasing cooperative for purposes of this title, and

''(2) such sponsor meets all requirements of this title applicable to a purchasing cooperative.

"SEC. 21222. QUALIFIED ASSOCIATION PLAN DEFINED.

''(a) GENERAL RULE.—For purposes of this subpart, a plan is a qualified association plan if the plan is a multiple employer welfare arrangement or similar arrangement—

''(1) which is maintained by a qualified association,

''(2) which has at least 500 participants in the United States,

''(3) under which the benefits provided consist solely of medical care (as defined in section 213(d) of the Internal Revenue Code of 1986),

''(4) which may not condition participation in the plan, or terminate coverage under the plan, on the basis of the health status or health claims expe-

rience of any employee or member or dependent of either,

''(5) which provides for bonding, in accordance with regulations providing rules similar to the rules under section 412 of the Employee Retirement Income Security Act of 1974, of all persons operating or administering the plan or involved in the financial affairs of the plan, and

''(6) which notifies each participant or provider that it is certified as meeting the requirements of this title applicable to it.

''(b) SELF-INSURED PLANS.—In the case of a plan which is not fully insured (within the meaning of section 514(b)(6)(D) of the Employee Retirement Income Security Act of 1974), the plan shall be treated as a qualified association plan only if—

''(1) the plan meets minimum financial solvency and cash reserve requirements for claims which are established by the Secretary of Labor and which shall be in lieu of any other such requirements under this title,

''(2) the plan provides an annual funding report (certified by an independent actuary) and annual financial statements to the Secretary of Labor and other interested parties, and

''(3) the plan appoints a plan sponsor who is responsible for operating the plan and ensuring compliance with applicable Federal and State laws.

''(c) CERTIFICATION.—

''(1) IN GENERAL.—A plan shall not be treated as a qualified association plan for any period unless there is in effect a certification by the Secretary of Labor that the plan meets the requirements of this subpart. For purposes of this title, the Secretary of Labor shall be the appropriate certifying authority with respect to the plan.

''(2) FEE.—The Secretary of Labor shall require a $5,000 fee for the original certification under paragraph (1) and may charge a reasonable annual fee to cover the costs of processing and reviewing the annual statements of the plan.

''(3) EXPEDITED PROCEDURES.—The Secretary of Labor may by regulation provide for expedited registration, certification, and comment procedures.

''(4) AGREEMENTS.—The Secretary of Labor may enter into agreements with the States to carry out the Secretary's responsibilities under this subpart.

''(d) AVAILABILITY.—Notwithstanding any other provision of this title, a qualified association plan may

limit coverage to individuals who are members of the qualified association establishing or maintaining the plan, an employee of such member, or a spouse or dependent of either.

''(e) SPECIAL RULES FOR EXISTING PLANS.—In the case of a plan in existence on January 1, 1994—

''(1) the requirements of subsection (a) (other than paragraph (4), (5), and (6) thereof) shall not apply,

''(2) no original certification shall be required under this subpart, and

''(3) no annual report or funding statement shall be required before January 1, 1996, but the plan shall file with the Secretary of Labor a description of the plan and the name of the plan sponsor.

"**SEC. 21223. DEFINITIONS AND SPECIAL RULES.**

''(a) QUALIFIED ASSOCIATION.—For purposes of this subpart, the term 'qualified association' means any organization which—

''(1) is organized and maintained in good faith by a trade association, an industry association, a professional association, a chamber of commerce, a religious organization, a public entity association, or other business association serving a common or similar industry,

''(2) is organized and maintained for substantial purposes other than to provide a health plan,

''(3) has a constitution, bylaws, or other similar governing document which states its purpose, and

''(4) receives a substantial portion of its financial support from its active, affiliated, or federation members.

''(b) MULTIPLE EMPLOYER WELFARE ARRANGEMENT.—For purposes of this subchapter, the term 'multiple employer welfare arrangement' has the meaning given such term by section 3(40) of the Employee Retirement Income Security Act of 1974.

''(c) COORDINATION WITH SUBPART B.—The term 'qualified association plan' shall not include a plan to which subpart B applies.

"Subpart B—Special Rule for Church, Multiemployer, and Cooperative Plans

"SEC. 21225. SPECIAL RULE FOR CHURCH, MULTIEMPLOYER, AND COOPERATIVE PLANS.

''(a) GENERAL RULE.—For purposes of this title, in the case of a health plan to which this section applies—

''(1) except as otherwise provided in this subpart, the plan shall be required to meet all applicable requirements of this title for certified health plans offered by experience-rated employers,

''(3) if such plan is certified as meeting such requirements, such plan shall be treated as a plan established and maintained by an experience-rated employer which meets the requirements of this title for experience-rated plans, and individuals enrolled in such plan shall be treated as experience-rated individuals, and

''(3) any individual eligible to enroll in the plan who does not enroll in the plan shall not be treated as an experience-rated individual solely by reason of being eligible to enroll in the plan.

''(b) MODIFIED STANDARDS.—

''(1) CERTIFYING AUTHORITY.—For purposes of this title, the Secretary of Labor shall be the appropriate certifying authority with respect to a plan to which this section applies.

''(2) AVAILABILITY.—Rules similar to the rules of subsection (d) of section 21222 shall apply to a plan to which this section applies.

''(3) ACCESS.—An employer which, pursuant to a collective bargaining agreement, offers an employee the opportunity to enroll in a plan described in subsection (c)(2) shall not be required to make any other plan available to the employee.

''(4) TREATMENT UNDER STATE LAWS.—A church plan described in subsection (c)(1) which is certified as meeting the requirements of this section shall not be deemed to be a multiple employer welfare arrangement or an insurance company or other insurer, or to be engaged in the business of insurance, for purposes of any State law purporting to regulate insurance companies or insurance contracts.

''(c) PLANS TO WHICH SECTION APPLIES.—This section shall apply to a health plan which—

''(1) is a church plan (as defined in section 414(e) of the Internal Revenue Code of 1986) which has at least 100 participants in the United States,

''(2) is a multiemployer plan (as defined in section 3(37) of the Employee Retirement Income Security Act of 1974) which is maintained by a health plan sponsor described in section 3(16)(B)(iii) of such Act and which has at least 500 participants in the United States, or

''(3) is a plan which is maintained by a rural electric cooperative or a rural telephone cooperative association (within the meaning of section 3(40) of such Act and which has at least 500 participants in the United States.

"PART IV—ACCESS THROUGH EMPLOYERS

"SEC. 21231. GENERAL EMPLOYER RESPONSIBILITIES.

''(a) PAYROLL DEDUCTION.—

''(1) IN GENERAL.—If—

''(A) a certified health plan, or purchasing cooperative on behalf of such a plan, requests an employer under this section to withhold premiums with respect to any employee enrolled in the plan, or

''(B) an employee requests an employer to withhold premiums to a certified health plan in which the employee is enrolled or enrolling,

the employer shall deduct and withhold such premiums (less any employer contribution) through payroll deduction and pay the amounts deducted and withheld to the plan or to the purchasing cooperative.

''(2) PAYROLL DEDUCTIONS.—

''(A) FREQUENCY.—In the case of an employee who is paid wages or other compensation—

''(i) on a monthly or more frequent basis, the employer shall deduct and withhold, and pay, such premiums at the same time as the payment of such wages or other compensation, or

''(ii) less frequently than monthly, the employer shall pay such premiums on a monthly basis.

''(B) EMPLOYEE PROTECTIONS.—

''(i) WITHHOLDING CONSTITUTES SATISFACTION OF OBLIGATION.—If an employee notifies the health plan sponsor that the employee has requested the employer withholding of a certain amount, the withholding of such an amount by the employer under subparagraph (A) shall constitute satisfaction of the employee's obligation to pay the health plan with respect to such amount.

''(ii) DIRECT PAYMENT ALLOWED IN CASE OF NONPAYMENT.—In the case of the nonpayment to a health plan of any amount withheld by an employer, the plan shall notify such employee of such nonpayment and shall allow the employee to make direct payments to the plan effective with the next succeeding payment period.

''(b) TIME PERIOD FOR EMPLOYERS.—An employer shall meet the requirements of this section with respect

to any new employee within the 30-day period beginning on the date of hire.

''SEC. 21232. DEVELOPMENT OF LARGE EMPLOYER PURCHASING GROUPS.

''Nothing in this title shall be construed as prohibiting 2 or more experience-rated employers from joining together to purchase insurance for their employees, except that each such employer shall be responsible for meeting the employer's requirements under this title with respect to its employees.

''SEC. 21233. REPORT TO EMPLOYEES ON EMPLOYER HEALTH CARE CONTRIBUTIONS.

''Each employer with more than 25 full-time employees shall report each year to each full-time employee the amount of the employer contributions made on behalf of the employee for health insurance coverage. An employer may use any reasonable means to carry out its responsibilities under this section (including the calculation of the amount of the employer contribution).

''SEC. 21234. EMPLOYER MAY NOT DISCRIMINATE AGAINST SUBSIDY ELIGIBLE INDIVIDUALS.

''(a) GENERAL RULE.—Any employer which elects to make employer contributions on behalf of its employees for health insurance coverage shall not condition, or vary, such contributions with respect to any employee by reason

of such employee's status as an individual eligible for premium assistance under subtitle B of title I of the America's Health Care Option Act.

''(b) ELIMINATION OF CONTRIBUTIONS.—An employer shall not be treated as failing to meet the requirements of subsection (a) if the employer ceases to make employer contributions for health insurance coverage for all its employees.

"SEC. 21235. ENFORCEMENT.

''A State program shall provide for the monitoring and enforcement of the requirements of this part.''.

Subtitle B—Consolidation of Federal Research

SEC. 211. CONSOLIDATION OF FEDERAL RESEARCH.

(a) AGENCY FOR QUALITY ASSURANCE AND CONSUMER INFORMATION.—

(1) IN GENERAL.—There is established within the Department of Health and Human Services an agency to be known as the Agency for Quality Assurance and Consumer Information (hereafter referred to in this section as the ''Agency'').

(2) PURPOSE.—The purpose of the Agency is to act as the center for all Federal research activities relating to quality and consumer information in health care.

(3) ADMINISTRATOR.—There shall be at the head of the Agency an official to be known as the Administrator for Quality Assurance and Consumer Information (hereafter referred to in this section as the ''Administrator''). The Administrator shall be appointed by the Secretary of Health and Human Services (hereafter referred to in this section as the ''Secretary'').

(b) CONSOLIDATION.—

(1) ACTION BY SECRETARY.— The Secretary, acting through the Administrator, shall consolidate Federal research activities relating to quality and consumer information in health care through the Agency to enable States to gain access to the results of such research from a central source.

(2) ACTION BY ADMINISTRATOR.—The Administrator shall assume the following responsibilities:

(A) Responsibilities of the Administrator for Health Care Policy and Research under title IX of the Public Health Service Act and under section 1142 of the Social Security Act.

(B) Responsibilities of the Director of the National Center for Health Statistics under section 306 of the Public Health Service Act.

(C) Responsibilities of the Director of the Office of Medical Applications of Research at the National Institutes of Health.

(D) Responsibilities of the Director of the Office of Research and Demonstrations of the Health Care Financing Administration, to the extent such responsibilities relate to clinical evaluations.

(c) DUTIES.—

(1) IN GENERAL.—In carrying out subsection (b)(1), the Secretary, acting through the Administrator, shall conduct and support research, demonstration projects, evaluations, training, guideline development, and the dissemination of information, on measures and standards of quality and consumer information relating to health care services and on systems for the delivery of such services. Activities under this section shall include—

(A) research with respect to the effectiveness and appropriateness of health care services and procedures;

(B) research with respect to quality management and improvement efforts of health care systems;

(C) the conduct of consumer information and surveys concerning—

(i) access to care;

(ii) use of health services;

(iii) health outcomes; and

(iv) patient satisfaction;

(D) the development, dissemination, application, and evaluation of practice guidelines;

(E) the conduct, in partnership with experts, of information effectiveness trials in the private sector; and

(F) the systematic evaluation of existing and new treatments and diagnostic technologies in an effort to improve the knowledge base to assist in clinical decision-making and policy choices.

(2) EXPERTS.—The Secretary, acting through the Administrator, shall carry out the activities described in paragraph (1) in consultation with private and public experts in quality and consumer information.

(3) GUIDELINES.—The Administrator shall develop and recommend to the Secretary minimum guidelines for health care quality measures, consumer information categories, and access to

health services. Such guidelines shall be utilized by the Secretary in establishing guidelines for certification under part III of subtitle B of title XXI of the Social Security Act.

(4) DATA.—The Administrator shall recommend to the Secretary standards and procedures for the administration of data and transactions relating to health care quality, consumer information, access, and effectiveness under subtitle B of title XI of the Social Security Act.

(5) RESEARCH.—The Agency shall be responsible for oversight with respect to basic and applied research concerning the matters described in paragraph (1).

(d) TRANSFERS.—There are hereby transferred to the Agency the staff, funds, and other assets of the agencies for which the Agency is assuming responsibilities under subsection (b)(2).

(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated $100,000,000 for fiscal year 1996, $150,000,000 for fiscal year 1997, $200,000,000 for each of the fiscal years 1998 and 1999, and $250,000,000 for fiscal year 2000. Beginning with fiscal year 1997, at least one-third of the funds for each year shall be used for im-

plementing the results of quality and consumer information research, such as grants to entities to test the use of practice guidelines in the health care delivery system.

Subtitle C—Self-Employed Individual and Small Employer Participation in Federal Employees Health Benefits Plans

SEC. 221. SELF-EMPLOYED INDIVIDUAL AND SMALL EMPLOYER PARTICIPATION IN FEDERAL EMPLOYEES HEALTH BENEFITS PLANS.

Part III of title 5, United States Code, is amended by inserting after chapter 89 the following new chapter:

"CHAPTER 90—SMALL BUSINESS PARTICIPATION IN FEDERAL EMPLOYEE HEALTH BENEFITS PLANS

"§ 9001. Definition

''(a) For purposes of this chapter, the term 'small business' means any business entity which employs 50 or less employees (including businesses with one self-employed individual).

''(b) For purposes of subsection (a), the rules under section 52 of the Internal Revenue Code of 1986 shall apply.

''(c) No entity, the sole purpose of which is to provide health care coverage for its members, shall be considered a small business for purposes of this chapter.

''§ 9002. Application to small business participants

''(a) The Office of Personnel Management shall promulgate regulations to apply the provisions of chapter 89, relating to health benefits plans, to the greatest extent practicable to small businesses and individuals covered under the provisions of this chapter.

''(b) Notwithstanding the provisions of subsection (a), carriers shall offer the same health benefits plans for the same premiums as are offered under chapter 89.

''(c) Notwithstanding the provisions of subsection (a), the provisions of section 8907 shall not apply to individuals covered under this chapter, except the Office of Personnel Management shall establish a method to disseminate information relating to health benefits plans (including information concerning periods of open enrollment and a summary of the information described in section 8908) to such individuals through small business participants and carriers.

''(d)(1) A carrier offering a health benefits plan under this chapter may charge a fee to participating small businesses for the administrative expenses related to the enrollment of such businesses in such plan, not to exceed the lesser of—

''(A) 15 percent of the premiums charged each such business, or

''(B) the amount charged each such business of the same size.

''(2) A carrier shall consult with the Office of Personnel Management before setting or adjusting any fee under this subsection.

''(e) A carrier offering a health benefits plan under this chapter may impose group participation requirements if such requirements are standard for all groups.

"§ 9003. Small business participation

''Any small business which desires to participate in a health benefits plan under this chapter may enter into a contract with a carrier in accordance with this chapter. Such contract shall provide for—

''(1) a term of no less than 1 year, and

''(2) early termination for nonpayment of premiums.

"§ 9004. Contributions

''(a) Subject to the provisions of subsection (b), an individual enrolled in a health benefits plan under this chapter shall make contributions equal to the amount of contributions made by—

''(1) a Federal enrollee in such plan under individual, or self and family coverage, as the case may be, as determined under section 8906;

''(2) the Federal agency making Government contributions determined under section 8906 for such Federal enrollee; and

''(3) the administrative charge applied by the carrier under section 9002(d).

''(b)(1) A small business may by contract agree to make any amount of the contribution required under subsection (a) on behalf of an enrollee under such subsection.

''(2) An agency of a State government may provide any amount of the contribution required under subsection (a) on behalf of an enrollee under such subsection.

''(c) A small business participating under this chapter shall—

''(1) collect contributions from employees by withholdings from pay or by another method or schedule;

''(2) make payments of such contributions to the contracted carrier;

''(3) maintain and make available such records as the Office, applicable State insurance authority, or carrier may require; and

''(4) provide any other related administrative service in carrying out the provisions of this chapter.

"§ 9005. Continued coverage

''(a) Subject to subsection (b), the provisions of section 8905a shall be made applicable to enrollees and individuals covered by such enrollments under this chapter through section 9002 and the carrier contract entered into under section 9003, except the enrollee shall pay all contributions for continued coverage and the applicable amount for administrative expenses unless the applicable small business by contract agrees to pay any part of such contributions or expenses.

''(b) An individual may be covered under continued coverage as provided under subsection (a), only if such individual—

''(1) was covered by a health benefits plan under this chapter for the 2-year period immediately preceding the date on which continued coverage under this section begins; and

''(2) remains in the same plan during the period of continued coverage as such individual was

enrolled in immediately before such period of continued coverage.''.

''§ 9006. Schedule of small business participation

''(a) Subject to the succeeding subsections of this section, each carrier enrolling individuals of small business participants under this chapter shall ensure that—

''(1) in the first contract year in which such carrier covers individuals of small business participants, the number of enrollees from small businesses as provided under this chapter shall be no less than 5 percent of the number of Federal enrollees enrolled by such carrier under chapter 89; and

''(2) in the second such year, the number of small business enrollees shall be no less than 10 percent of the number of such Federal enrollees;

''(3) in the third such year, the number of small business enrollees shall be no less than 10 percent of the number of such Federal enrollees; and

''(4) in the fourth such year, the number of small business enrollees shall be no less than 10 percent of the number of such Federal enrollees.

''(b)(1) In the contract year described under subsection (a)(1), a small business may participate if such business has between 5 and 50 employees.

''(2) In the contract year described under subsection (a)(2) small businesses with between 2 and 50 employees may additionally participate.

''(3) In the contract year described under subsection (a)(3) and each year thereafter, all small businesses may participate.

''(c) If during any contract year described under subsection (a) (1) through (4), more small businesses apply for participation than are required to participate under such subsection, the carrier shall ensure that a small business shall have a priority for selection for participation if such business is not offering any type of health insurance benefits to its employees.

''(d)(1) If a carrier that enrolls individuals of small business participants under this chapter, ceases to offer enrollment to individuals under this chapter in any contract year, such carrier may not offer enrollment under this chapter for the following 2 contract years.

''(2) The provisions of paragraph (1) shall not be construed to require any carrier to terminate health coverage of any individual who is enrolled under this chapter at the time such carrier ceases to offer new enrollments under this chapter.

''(e) A small business may participate in a health benefits plan as provided under this section if such business

meets all such requirements otherwise provided under this chapter.

''(f) The Office may waive the requirements under subsection (a), in whole or in part, after making a determination that—

''(1) there is insufficient interest in small businesses within the region in participating under this chapter; or

''(2) a requirement is beyond the capacity of a carrier to enroll individuals under this chapter.

''§ 9007. Cost comparison reports and reductions

''(a) No later than July 1 of the first contract year implementing health care coverage under this chapter, and on July 1 of each year thereafter, each carrier contracting under chapter 89 or this chapter shall submit a report to the Office of Personnel Management that compares the aggregate cost experiences with respect to coverage between—

''(1) Federal employees and other individuals covered under chapter 89; and

''(2) individuals covered under this chapter.

''(b) Based on the reports submitted under subsection (a), the Office may reduce the percentage requirements under section 9006(a) for any contract year (but not below the percentage of the preceding contract year).''.

SEC. 222. PROHIBITION OF HEALTH BENEFITS PLANS EXCLUSIVELY FOR MEMBERS AND EMPLOYEES OF CONGRESS.

No health benefits plan under chapter 89 or 90 of title 5, United States Code, may be offered exclusively to—

(1) Members of Congress (including members of family);

(2) congressional employees as defined under section 2107 of such title (including members of family); or

(3) individuals described under paragraphs (1) and (2).

SEC. 223. STUDY REGARDING NONWORKER AND NONCOVERED EMPLOYEE BUY-INS.

The Secretary of Health and Human Services shall study by what method nonworkers and employees of employers not covered under chapter 90 of title 5, United States Code (as added by section 221 of this Act), may be incorporated into the buy-in for coverage under the Federal Employees Health Benefits Plan. The Secretary shall report the results of such study and any appropriate legislative recommendations to the Congress not later than 2 years after the date of the enactment of this Act.

SEC. 224. EFFECTIVE DATE.

(a) IN GENERAL.—Except as provided under subsection (b), the provisions of this subtitle and the amendments made by this subtitle shall be effective on and after the first January 1 occurring after the date of the enactment of this Act.

(b) EXCEPTION.—The provisions of chapters 89 and 90 of title 5, United States Code, as amended and effected by this subtitle, relating to the establishment of or exercise of authority (including the promulgation of regulations) by the Office of Personnel Management, the Secretary of Health and Human Services, the President, or any other applicable Federal officer shall take effect on the date of the enactment of this Act in order to establish health benefits plans and fully implement the provisions and amendments made by this Act no later than the first January 1 occurring after the date of the enactment of this Act.

Subtitle D—Report on Health Care System

SEC. 231. REPORT ON HEALTH CARE SYSTEM.

(a) REPORT.—Not later than July 1, 1998, the President shall submit to the Congress findings and recommendations (if any) on each of the items described in subsection (b).

(b) ITEMS TO BE STUDIED.—The items referred to in subsection (a) are as follows:

(1) The characteristics of the insured and uninsured, including demographic characteristics, working status, health status, and geographic distribution.

(2) Methods to improve access to health care and to increase health insurance coverage of the chronically uninsured.

(3) The effectiveness of the insurance reforms under subtitle A on access to health care and the costs of health care.

(4) The effectiveness of Federal efforts to assess the impact of new technology on the cost and availability of new products.

(5) The effectiveness of Federal, State, and private cost containment strategies.

(6) The effectiveness of Federal, State, and private efforts to measure and improve health care outcomes.

(7) The effectiveness of the new Federal subsidy programs, including recommendations to restrain future growth.

(8) The effectiveness of initiatives targeted to underserved urban and rural populations.

TITLE III—SPECIAL ASSISTANCE FOR RURAL, FRONTIER AND UNDERSERVED URBAN AREAS

SEC. 301. PURPOSE.

It is the purpose of this title to—

(1) establish safeguards to assist vulnerable populations in accessing local health services and practitioners;

(2) provide funding to certain areas to assist health care providers and health plans in such areas in reconfiguring services and establishing networks and health plans to effectively compete in the changing market;

(3) provide funding to increase primary care capacity in underserved areas; and

(4) provide more flexibility in Medicare rules for health care providers in underserved areas.

SEC. 302. DESIGNATED UNDERSERVED AREAS.

(a) STATE DESIGNATION.—A State may designate certain rural, frontier or urban areas within the State as underserved areas based on—

(1) the lack of access to health plans in such areas; and

(2) the lack of access to quality health care providers and health care facilities in such areas.

(b) ESTABLISHMENT OF PROCEDURE.—

(1) IN GENERAL.—The Secretary shall establish a procedure under which the Secretary, upon the request of a State, may certify areas designated by the State under subsection (a) as underserved areas.

(2) NONAPPLICABILITY OF OTHER REQUIREMENTS.—The Secretary may certify a designated area under paragraph (1) whether or not such area meets the requirements for being considered a medically underserved area or a health professional shortage area.

(c) EFFECT OF CERTIFICATION.—Except with respect to provisions in this title that explicitly direct assistance to those areas currently designated as underserved, in awarding grants, contracts, loans, waivers, or any other assistance under this title (or an amendment made by this title) the Secretary shall give priority to applicants that serve areas certified as underserved areas under subsection (b).

(d) LIMITATION AND REVOCATION.—A certification provided under subsection (b) shall be valid for not more than 3 years. Such a certification may be revoked by the Secretary if the Secretary determines that the criteria described in paragraphs (1) and (2) of subsection (a) no longer support a certification under this section.

Subtitle A—Planning, Demonstrations, and Grants

SEC. 311. DEMONSTRATION WAIVERS FOR THE DEVELOPMENT OF HEALTH NETWORKS.

(a) WAIVERS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary may conduct a demonstration project under which public or private entities may apply for waivers of any of the provisions of title XVIII and XIX of the Social Security Act in order to operate health networks (as defined in subsection (c)(1)) which—

(i) improve the access of medicare beneficiaries (as defined in subsection (c)(2)) and medicaid beneficiaries (as defined in subsection (c)(3)) to health care services;

(ii) improve the quality of health care services furnished to such beneficiaries;

(iii) improve the outcomes of health care services furnished to such beneficiaries; and

(iv) provide an incentive to private entities to establish networks in areas cer-

tified as underserved areas under section 302.

(B) NUMBER OF WAIVERS.—The Secretary may grant waivers to operate health networks under the demonstration project conducted under this section to a number of public or private entities determined appropriate by the Secretary.

(2) APPLICATIONS.—

(A) IN GENERAL.—In order to participate in the demonstration project conducted under this subsection, a public or private entity desiring to operate a health network shall submit an application to the Secretary which meets the requirements of subparagraph (B). Such application shall be submitted in such manner and at such time as the Secretary shall require.

(B) REQUIREMENTS.—An application submitted by a public or private entity under this subsection must provide—

(i) a description of the health care providers participating in the health network;

(ii) a description of the geographic area served by the health networks;

(iii) information demonstrating that the private entity has consulted with interested parties with respect to the operation of the health network, including local government entities and community groups;

(iv) a description of the operational structure of the health network, including whether the network is a managed care entity or a fee-for-service provider;

(v) a proposal for how payments should be made to the health network under titles XVIII and XIX of the Social Security Act, including a statement as to whether such payments should be made pursuant to the provisions of such titles or pursuant to an alternative payment methodology described in the application;

(vi) assurances that medicare beneficiaries served by the health network will receive care and services of the same quality as the care and services received by other beneficiaries under title XVIII of the Social Security Act;

(vii) assurances that medicaid beneficiaries served by the health network will

receive care and services of the same quality as the care and services received by other beneficiaries under title XIX of the Social Security Act;

(viii) a description of how the health network plans to handle any situation in which a medicare beneficiary or medicaid beneficiary served by the network receives health care services from providers outside the network;

(ix) assurances that the health network is furnishing health care services to a significant number of individuals who are not receiving benefits under titles XVIII and XIX of the Social Security Act;

(x) assurances that through sharing of facilities, land, and equipment, the health network will result in a reduction of total capital costs for the area served by the network;

(xi) a plan for cooperation in service delivery by health care providers participating in the health network that demonstrates the elimination of unnecessary duplication and, when appropriate, the

consolidation of specialized services within the area served by the network;

(xii) evidence that the health network furnishes services which address the special access needs of the medicare beneficiaries and medicaid beneficiaries served by the network;

(xiii) evidence of capability and expertise in network planning and management; and

(xiv) such additional information as the Secretary determines appropriate.

(C) APPROVAL OF APPLICATION.—

(i) INITIAL REVIEW.—Within 60 days after an application is submitted by an entity under this subsection, the Secretary shall review and approve such application or provide the entity with a list of the modifications that are necessary for such application to be approved.

(ii) ADDITIONAL REVIEW.—Within 60 days after an entity resubmits any application under this subsection, the Secretary shall review and approve such application or provide the entity with a summary of

which items included on the list provided to the State under clause (i) remain unsatisfied. An entity may resubmit an application under this subparagraph as many times as necessary to gain approval.

(3) COORDINATION WITH OTHER PROGRAMS.—The Secretary shall coordinate the demonstration project conducted under this subsection with any other relevant Federal or State programs in order to prevent duplication and improve the quality and delivery of health care services to medicare beneficiaries and medicaid beneficiaries.

(4) PAYMENTS TO NETWORKS.—

(A) IN GENERAL.—The Secretary shall determine the amount of payments to be made under titles XVIII and XIX to a health network participating in a demonstration project under this subsection based on historic costs adjusted based on population and geographic area as the Secretary determines appropriate to take into account the costs of furnishing health care services in the area served by the network.

(B) BUDGET NEUTRALITY.—The Secretary shall provide that in carrying out the demonstration project under this section, the aggre-

gate payments under titles XVIII and XIX of the Social Security Act to providers participating in a health network shall be no greater or lesser than what such payments would have been if such providers were not participating in such network.

(5) DURATION OF WAIVERS.—Any waiver granted under the demonstration project conducted under this subsection shall be granted for a period determined appropriate by the Secretary. The Secretary may terminate such a waiver at any time if the Secretary determines that the health network has failed to furnish health care services in accordance with the terms of the waiver.

(6) REPORTS.—

(A) IN GENERAL.—Each entity receiving a wavier to operate a health network under the demonstration project conducted under this subsection shall, through an independent entity, evaluate the network and submit interim and final reports to the Secretary at such times and containing such information as the Secretary shall require.

(B) REPORT TO CONGRESS.—Not later than 60 days after the receipt of a final report

by a health network under subparagraph (A) the Secretary shall submit a report to Congress.

(b) DEVELOPMENTAL GRANTS.—

(1) IN GENERAL.—The Secretary shall award grants to entities which have received a wavier under the demonstration project conducted under subsection (a) for the purpose of planning and developing health networks.

(2) APPLICATION PROCESS.—

(A) SUBMISSION OF APPLICATION.—Each entity desiring to receive a grant under this subsection shall submit an application to the Secretary at such time and containing such information as the Secretary determines appropriate.

(B) CONSIDERATION OF APPLICATIONS.—The Secretary shall develop a system for determining the priority for distributing grants under this subsection and such grants shall be distributed in accordance with such system.

(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for the purposes of awarding grants under this subsection.

(c) DEFINITIONS.—For purposes of this section:

(1) FRONTIER AREA.—The term ''frontier area'' means an area in which 6 or fewer individuals reside per square mile.

(2) HEALTH NETWORK.—The term ''health network'' means a formal cooperative arrangement between participating hospitals, physicians, and other health care providers which—

(A) furnishes health care services to members of the community, including medicare beneficiaries and medicaid beneficiaries;

(B) is located in a rural, frontier or underserved urban area; and

(C) is governed by a board of directors selected by participating health care providers.

(3) MEDICAID BENEFICIARY.—The term ''medicaid beneficiary'' means an individual receiving benefits under this XIX of the Social Security Act who resides in a rural, frontier or underserved urban area or who receives health care services from a health care provider located in a rural, frontier or underserved urban area.

(4) MEDICARE BENEFICIARY.—The term ''medicare beneficiary'' means an individual receiving benefits under title XVIII of the Social Security Act who resides in a rural, frontier or underserved urban

area or who receives health care services from a health care provider located in a rural, frontier or underserved urban area.

(5) RURAL AREA.—The term ''rural area'' means a rural area as described in section 1886(d)(2)(D) of the Social Security Act.

(6) UNDERSERVED URBAN AREA.—The term ''underserved urban area'' means an area (other than a rural area) determined to be underserved by the Secretary.

SEC. 312. GRANTS FOR THE PLANNING OF HEALTH NETWORKS OR HEALTH PLANS.

Title XX of the Social Security Act (42 U.S.C. 1397 et seq.) is amended—

(1) in the title heading, by adding at the end thereof the following: ''AND MISCELLANEOUS PROVISIONS'';

(2) by inserting after the title heading the following:

"Subtitle A—Block Grants"; and

(3) by adding at the end thereof the following:

"Subtitle B—Health Plans and Networks Initiated by Private Entities

''GRANTS FOR THE PLANNING OF HEALTH NETWORKS AND HEALTH PLANS

''SEC. 2011. (a) IN GENERAL.—The Secretary shall award grants to private entities submitting applications that are approved under subsection (b) for the purpose of planning and developing health networks or health plans to serve underserved areas certified under section 302 of the America's Health Care Option Act.

''(b) APPLICATION PROCESS.—

''(1) SUBMISSION OF APPLICATION.—Each private entity desiring to receive a grant under this section shall submit an application to the Secretary at such time and containing such information as the Secretary determines appropriate, including—

''(A) a description of the health care providers that will participate in the health network or serve through the health plan;

''(B) a description of the geographic area to be served by the health network or plan;

''(C) information demonstrating that the private entity has consulted with interested parties with respect to the operation of the health

network or plan, including local government entities and community groups;

''(D) a description of the operational structure of the health network or plan, including whether the network is a managed care entity or a fee-for-service provider;

''(E) assurances that through sharing of facilities, land, and equipment, the health network will result in a reduction of total capital costs for the area served by the network;

''(F) a plan for cooperation in service delivery by health care providers participating in the health network or plan that demonstrates the elimination of unnecessary duplication and, when appropriate, the consolidation of specialized services within the area served by the network or plan;

''(G) evidence that the health network will furnish services which address the special access needs of the individuals served by the network;

''(H) a demonstration that the health plan developed will improve access to services for the community served; and

''(I) evidence of capability and expertise in network planning, health plans and management.

''(2) CONSIDERATION OF APPLICATIONS.—The Secretary shall develop a system for determining the priority for distributing grants under this section and such grants shall be distributed in accordance with such system.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for the purposes of awarding grants under this section.

''(d) DEFINITIONS.—For purposes of this section, the term ''health network'' has the same meaning given such term in section 311(c)(1) of the America's Health Care Option Act.''.

SEC. 313. COMMUNITY-BASED PRIMARY HEALTH CARE GRANT PROGRAM.

Subpart I of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following new section:

"SEC. 330A. COMMUNITY-BASED PRIMARY HEALTH CARE GRANT PROGRAM.

''(a) ESTABLISHMENT.—The Secretary shall establish and administer a program to provide allotments to

States to enable such States to provide grants for the creation or enhancement of community-based primary health care entities that provide services to low-income or medically underserved populations.

''(b) ALLOTMENTS TO STATES.—

''(1) IN GENERAL.—From the amount available for allotment under subsection (h) for a fiscal year, the Secretary shall allot to each State an amount equal to the product of the grant share of the State (as determined under paragraph (2)) multiplied by such amount available.

''(2) GRANT SHARE.—

''(A) IN GENERAL.—For purposes of paragraph (1), the grant share of a State shall be the product of the need-adjusted population of the State (as determined under subparagraph (B)) multiplied by the Federal matching percentage of the State (as determined under subparagraph (C)), expressed as a percentage of the sum of the products of such factors for all States.

''(B) NEED-ADJUSTED POPULATION.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the need-adjusted population of a State shall be the product of

the total population of the State (as estimated by the Secretary of Commerce) multiplied by the need index of the State (as determined under clause (ii)).

''(ii) NEED INDEX.—For purposes of clause (i), the need index of a State shall be the ratio of—

''(I) the weighted sum of the geographic percentage of the State (as determined under clause (iii)), the poverty percentage of the State (as determined under clause (iv)), and the multiple grant percentage of the State (as determined under clause (v)); to

''(II) the general population percentage of the State (as determined under clause (vi)).

''(iii) GEOGRAPHIC PERCENTAGE.—

''(I) IN GENERAL.—For purposes of clause (ii)(I), the geographic percentage of the State shall be the estimated population of the State that is residing in nonurbanized areas (as determined under subclause (II)) ex-

pressed as a percentage of the total nonurbanized population of all States.

''(II) NONURBANIZED POPULATION.—For purposes of subclause (I), the estimated population of the State that is residing in nonurbanized areas shall be one minus the urbanized population of the State (as determined using the most recent decennial census), expressed as a percentage of the total population of the State (as determined using the most recent decennial census), multiplied by the current estimated population of the State.

''(III) STATE OF ALASKA.—Notwithstanding subclause (I), the geographic percentage for the State of Alaska shall be the relative population density of the State expressed as the ratio of—

''(aa) the average number of individuals residing in Alaska per square mile; to

''(bb) the average number of individuals residing in the United States per square mile.

''(iv) POVERTY PERCENTAGE.—For purposes of clause (ii)(I), the poverty percentage of the State shall be the estimated number of people residing in the State with incomes below 200 percent of the income official poverty line (as adjusted for actual costs and incomes in each State and as determined by the Office of Management and Budget) expressed as a percentage of the total number of such people residing in all States.

''(v) MULTIPLE GRANT PERCENTAGE.—For purposes of clause (ii)(I), the multiple grant percentage of the State shall be the amount of Federal funding received by the State under grants awarded under sections 329, 330, and 340, expressed as a percentage of the total amounts received under such grants by all States. With respect to a State, such percentage shall not exceed twice the general population percentage of the State under

clause (vi) or be less than one-half of the States general population percentage.

''(vi) GENERAL POPULATION PERCENTAGE.—For purposes of clause (ii)(II), the general population percentage of the State shall be the total population of the State (as determined by the Secretary of Commerce) expressed as a percentage of the total population of all States.

''(C) FEDERAL MATCHING PERCENTAGE.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the Federal matching percentage of the State shall be equal to one, less the State matching percentage (as determined under clause (ii)).

''(ii) STATE MATCHING PERCENTAGE.—For purposes of clause (i), the State matching percentage of the State shall be 0.25 multiplied by the ratio of the total taxable resource percentage (as determined under clause (iii)) to the need-adjusted population of the State (as determined under subparagraph (B)).

''(iii) TOTAL TAXABLE RESOURCE PERCENTAGE.—For purposes of clause (ii),

the total taxable resources percentage of the State shall be the total taxable resources of a State (as determined by the Secretary of the Treasury) expressed as a percentage of the sum of the total taxable resources of all States.

''(3) ANNUAL ESTIMATES.—

''(A) IN GENERAL.—If the Secretary of Commerce does not produce the annual estimates required under paragraph (2)(B)(iv), such estimates shall be determined by multiplying the percentage of the population of the State that is below 200 percent of the income official poverty line as determined using the most recent decennial census by the most recent estimate of the total population of the State. Except as provided in subparagraph (B), the calculations required under this subparagraph shall be made based on the most recent 3-year average of the total taxable resources of individuals within the State.

''(B) DISTRICT OF COLUMBIA.—Notwithstanding subparagraph (A), the calculations required under such subparagraph with respect to the District of Columbia shall be based on the

most recent 3-year average of the personal income of individuals residing within the District as a percentage of the personal income for all individuals residing within the District, as determined by the Secretary of Commerce.

''(C) STATE OF ALASKA.—Notwithstanding subparagraph (A), the calculations required under such subparagraph with respect to the State of Alaska shall be based on the quotient of—

''(i) the most recent 3-year average of the per capita income of individuals residing in the State; divided by

''(ii) 1.25.

''(4) MATCHING REQUIREMENT.—A State that receives an allotment under this section shall make available State resources (either directly or indirectly) to carry out this section in an amount that shall equal the State matching percentage for the State (as determined under paragraph (2)(C)(ii)) divided by the Federal matching percentage (as determined under paragraph (2)(C)).

''(c) APPLICATION.—

''(1) IN GENERAL.—To be eligible to receive an allotment under this section, a State shall prepare

and submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may by regulation require.

''(2) ASSURANCES.—A State application submitted under paragraph (1) shall contain an assurance that—

''(A) the State will use amounts received under its allotment consistent with the requirements of this section; and

''(B) the State will provide, from non-Federal sources, the amounts required under subsection (b)(4).

''(d) USE OF FUNDS.—

''(1) IN GENERAL.—The State shall use amounts received under this section to award grants to eligible public and nonprofit private entities, or consortia of such entities, within the State to enable such entities or consortia to provide services of the type described in paragraph (2) of section 329(h) to low-income or medically underserved populations.

''(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1), an entity or consortium shall—

''(A) prepare and submit to the administering entity of the State, an application at

such time, in such manner, and containing such information as such administering entity may require, including a plan for the provision of services of the type described in paragraph (3);

''(B) provide assurances that services will be provided under the grant at fee rates established or determined in accordance with section 330(e)(3)(F); and

''(C) provide assurances that in the case of services provided to individuals with health insurance, such insurance shall be used as the primary source of payment for such services.

''(3) SERVICES.—The services to be provided under a grant awarded under paragraph (1) shall include—

''(A) one or more of the types of primary health services described in section 330(b)(1);

''(B) one or more of the types of supplemental health services described in section 330(b)(2); and

''(C) any other services determined appropriate by the administering entity of the State.

''(4) TARGET POPULATIONS.—Entities or consortia receiving grants under paragraph (1) shall, in providing the services described in paragraph (3),

substantially target populations of low-income or medically underserved populations within the State who reside in medically underserved or health professional shortage areas, areas certified as underserved under the rural health clinic program, or other areas determined appropriate by the administering entity of the State, within the State.

''(5) PRIORITY.—In awarding grants under paragraph (1), the State shall—

''(A) give priority to entities or consortia that can demonstrate through the plan submitted under paragraph (2) that—

''(i) the services provided under the grant will expand the availability of primary care services to the maximum number of low-income or medically underserved populations who have no access to such care on the date of the grant award; and

''(ii) the delivery of services under the grant will be cost-effective; and

''(B) ensure that an equitable distribution of funds is achieved among urban and rural entities or consortia.

''(e) REPORTS AND AUDITS.—Each State shall prepare and submit to the Secretary annual reports concern-

ing the State's activities under this section which shall be in such form and contain such information as the Secretary determines appropriate. Each such State shall establish fiscal control and fund accounting procedures as may be necessary to assure that amounts received under this section are being disbursed properly and are accounted for, and include the results of audits conducted under such procedures in the reports submitted under this subsection.

''(f) PAYMENTS.—

''(1) ENTITLEMENT.—Each State for which an application has been approved by the Secretary under this section shall be entitled to payments under this section for each fiscal year in an amount not to exceed the State's allotment under subsection (b) to be expended by the State in accordance with the terms of the application for the fiscal year for which the allotment is to be made.

''(2) METHOD OF PAYMENTS.—The Secretary may make payments to a State in installments, and in advance or by way of reimbursement, with necessary adjustments on account of overpayments or underpayments, as the Secretary may determine.

''(3) STATE SPENDING OF PAYMENTS.—Payments to a State from the allotment under sub-

section (b) for any fiscal year must be expended by the State in that fiscal year or in the succeeding fiscal year.

''(g) DEFINITION.—As used in this section, the term 'administering entity of the State' means the agency or official designated by the chief executive officer of the State to administer the amounts provided to the State under this section.

''(h) FUNDING.—Notwithstanding any other provision of law, the Secretary shall use 50 percent of the amounts that the Secretary is required to utilize under section 330B(h) in each fiscal year to carry out this section.''.

Subtitle B—Technical Assistance Grants

SEC. 321. TECHNICAL ASSISTANCE GRANTS.

(a) IN GENERAL.—The Secretary shall award grants to public and private entities submitting applications that are approved under subsection (b) for the purpose of providing technical assistance in the establishment of the infrastructure for health networks and plans in underserved areas certified under section 302.

(b) APPLICATION PROCESS.—

(1) SUBMISSION OF APPLICATION.—Each entity desiring to receive a grant under this section shall

submit an application to the Secretary at such time and containing such information as the Secretary determines appropriate, including—

(A) a description of the infrastructure uses to which amounts awarded under a grant will be allocated;

(B) a description of the area to be served by the entity; and

(C) information demonstrating that the entity has consulted with interested parties with respect to the activities that the entity intends to carry out with amounts received under the grant, including local government entities and community groups.

(2) CONSIDERATION OF APPLICATIONS.—The Secretary shall develop a system for determining the priority for distributing grants under this section and such grants shall be distributed in accordance with such system. The Secretary shall give priority to applications that demonstrate partnerships among health care providers and services (both public and private) and effective coordination of all sources of grants and other funding sources under this Act.

(c) AUTHORIZED USES.—Amounts received under a grant awarded under this section may be used—

(1) for the design and establishment of the infrastructure necessary for the operation of a health network or health plan in a rural, frontier or urban underserved area;

(2) to assist health plans operating in rural, frontier or urban underserved areas in meeting the requirements of any subsidy program;

(3) to carry out activities to assist health care providers in forming partnerships or health plans to serve rural, frontier or urban underserved areas, including assistance with the establishment of financial systems, computer systems, and telecommunications systems; and

(4) to carry out any other activity determined appropriate by the Secretary.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for the purposes of awarding grants under this section.

(e) DEFINITIONS.—For purposes of this section, the terms ''health network'', ''rural area'', ''frontier area'', and ''urban underserved area'' have the same meanings given such terms in section 311(c).

Subtitle C—Capital Assistance Loans and Loan Guarantees

SEC. 331. RURAL, FRONTIER AND URBAN UNDERSERVED AREA HEALTH LOAN PROGRAM.

(a) IN GENERAL.—The Secretary shall make loans to—

(1) health networks (as defined in section 311(c));

(2) health plans (as defined in section 21003(a) of the Social Security Act) that cover individuals residing in rural, frontier or urban underserved areas; or

(3) health care providers that serve rural, frontier or underserved urban areas;

for the capital costs of developing health delivery systems and expanding existing health delivery sites to make health care services available to individuals residing in underserved areas certified under section 302.

(b) USE OF ASSISTANCE.—

(1) IN GENERAL.—The capital costs for which loans made pursuant to subsection (a) may be expended are, subject to paragraphs (2) and (3), the following:

(A) The modernization or expansion of facilities to reduce the inpatient characteristics of

such facilities while expanding the ambulatory capabilities of such facilities, to enhance the provision and accessibility of health care services and practitioners to underserved populations.

(B) The conversion of unneeded facilities to facilities that will assure or enhance the provision and accessibility of health care services and practitioners to underserved populations, or the closure of such facilities in an effort to consolidate clinical and administrative activities for network purposes.

(C) The acquisition or modernization of facilities or purchase of land to facilitate the service of rural, frontier and urban underserved populations through health care networks or health plans.

(D) The purchase of major equipment, including equipment necessary for the support of information systems, for the operation of a health care network or a health care plan serving residents of rural, frontier and urban underserved areas.

(E) The development and implementation of systems (financial, quality assurance and

other systems) necessary to establish health care networks.

(F) The development of appropriate primary care services and practitioners.

(G) The implementation of measures necessary to enable a health care network, health plan, or health care provider that serves rural, frontier or urban underserved areas to comply with applicable quality, safety or environmental requirements.

(H) Such other capital costs as the Secretary may determine are necessary to achieve the objectives of this section, including start-up expenses, reserve funds, and other financial requirements applicable to networks, plans or providers.

(2) PRIORITIES REGARDING USE OF FUNDS.—In providing loans under subsection (a) for an entity, the Secretary shall give priority to authorizing the use of amounts for projects for the renovation and modernization of medical facilities necessary to prevent or eliminate safety hazards, avoid noncompliance with licensure or accreditation standards, or projects to replace obsolete facilities.

(3) LIMITATION.—The Secretary may authorize the use of loans under subsection (a) for the construction of new buildings only if the Secretary determines that appropriate facilities are not available through acquiring, modernizing, expanding or converting existing buildings, or that construction new buildings will cost less.

(c) AMOUNT OF ASSISTANCE.—The principal amount of loans under subsection (a) may cover up to 100 percent of the costs involved.

SEC. 332. CERTAIN REQUIREMENTS.

(a) IN GENERAL.—The Secretary may approve a loan under section 331 only if—

(1) an application for such assistance is submitted to the Secretary in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subtitle;

(2) the Secretary is reasonably satisfied that the applicant for the project for which the loan would be made will be able to make payments of principal and interest thereon when due; and

(3) the applicant provides the Secretary with reasonable assurances that there will be available to it such additional funds as may be necessary to com-

plete the project or undertaking with respect to which such loan is requested.

(b) TERMS AND CONDITIONS.—Any loan made under section 331 shall, subject to the Federal Credit Reform Act of 1990, meet such terms and conditions (including provisions for recovery in case of default) as the Secretary, in consultation with the Secretary of the Treasury, determines to be necessary to carry out the purposes of such section while adequately protecting the financial interests of the United States. Terms and conditions for such loans shall include provisions regarding the following:

(1) Security.

(2) Maturity date.

(3) Amount and frequency of installments.

(4) Rate of interest, which shall be at a rate comparable to the rate of interest prevailing on the date the loan is made.

SEC. 333. DEFAULTS.

(a) IN GENERAL.—The Secretary may take such action as may be necessary to prevent a default on loans under section 331, including the waiver of regulatory conditions, deferral of loan payments, renegotiation of loans, and the expenditure of funds for technical and consultative assistance, for the temporary payment of the interest and principal on such a loan, and for other purposes.

(b) FORECLOSURE.—The Secretary may take such action, consistent with State law respecting foreclosure procedures, as the Secretary deems appropriate to protect the interest of the United States in the event of a default on a loan made pursuant to section 331, including selling real property pledged as security for such a loan and for a reasonable period of time taking possession of, holding, and using real property pledged as security for such a loan.

(c) WAIVERS.—The Secretary may, for good cause, but with due regard to the financial interests of the United States, waive any right of recovery which the Secretary has by reasons of the failure of a borrower to make payments of principal of and interest on a loan made pursuant to section 331, except that if such loan is sold and guaranteed, any such waiver shall have no effect upon the Secretary's guarantee of timely payment of principal and interest.

Subtitle D—Increasing Primary Care Providers

SEC. 341. NONREFUNDABLE CREDIT FOR CERTAIN PRIMARY HEALTH SERVICES PROVIDERS.

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to nonrefundable personal credits) is

amended by inserting after section 22 the following new section:

"SEC. 23. PRIMARY HEALTH SERVICES PROVIDERS.

''(a) ALLOWANCE OF CREDIT.—There shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the product of—

''(1) the number of months during such taxable year—

''(A) during which the taxpayer is a qualified primary health services provider, and

''(B) which are within the taxpayer's mandatory service period, and

''(2) $1,000 ($500 in the case of a qualified practitioner who is not a physician).

''(b) QUALIFIED PRIMARY HEALTH SERVICES PROVIDER.—For purposes of this section, the term 'qualified primary health services provider' means, with respect to any month, any qualified practitioner who—

''(1) has in effect a certification by the Bureau as a provider of primary health services and such certification is, when issued, for a health professional shortage area in which the qualified practitioner is commencing the providing of primary health services,

''(2) is providing primary health services full time in the health professional shortage area identified in such certification, and

''(3) has not received a scholarship under the National Health Service Corps Scholarship Program or any loan repayments under the National Health Service Corps Loan Repayment Program.

For purposes of paragraph (2) and subsection (e)(3), a provider shall be treated as providing services in a health professional shortage area when such area ceases to be such an area if it was such an area when the provider commenced providing services in the area.

''(c) MANDATORY SERVICE PERIOD.—For purposes of this section, the term 'mandatory service period' means the period of 60 consecutive calendar months beginning with the first month the taxpayer is a qualified primary health services provider. A taxpayer shall not have more than 1 mandatory service period.

''(d) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

''(1) BUREAU.—The term 'Bureau' means the Bureau of Primary Health Care, Health Resources and Services Administration of the United States Public Health Service.

''(2) QUALIFIED PRACTITIONER.—The term 'qualified practitioner' means a physician, a physician assistant, a nurse practitioner, or a certified nurse-midwife.

''(3) PHYSICIAN.—The term 'physician' has the meaning given to such term by section 1861(r) of the Social Security Act.

''(4) PHYSICIAN ASSISTANT; NURSE PRACTITIONER.—The terms 'physician assistant' and 'nurse practitioner' have the meanings given to such terms by section 1861(aa)(5) of the Social Security Act.

''(5) CERTIFIED NURSE-MIDWIFE.—The term 'certified nurse-midwife' has the meaning given to such term by section 1861(gg)(2) of the Social Security Act.

''(6) PRIMARY HEALTH SERVICES.—The term 'primary health services' has the meaning given such term by section 330(b)(1) of the Public Health Service Act.

''(7) HEALTH PROFESSIONAL SHORTAGE AREA.—The term 'health professional shortage area' has the meaning given such term by section 332(a)(1)(A) of the Public Health Service Act.

''(e) RECAPTURE OF CREDIT.—

''(1) IN GENERAL.—If there is a recapture event during any taxable year, then—

''(A) no credit shall be allowed under subsection (a) for such taxable year and any succeeding taxable year, and

''(B) the tax of the taxpayer under this chapter for such taxable year shall be increased by an amount equal to the product of—

''(i) the applicable percentage, and

''(ii) the aggregate unrecaptured credits allowed to such taxpayer under this section for all prior taxable years.

''(2) APPLICABLE RECAPTURE PERCENTAGE.—

''(A) IN GENERAL.—For purposes of this subsection, the applicable recapture percentage shall be determined from the following table:

"If the recapture event occurs during:	**The applicable recapture percentage is:**
Months 1–24	100
Months 25–36	75
Months 37–48	50
Months 49–60	25
Month 61 or thereafter	0.

''(B) TIMING.—For purposes of subparagraph (A), month 1 shall begin on the first day of the mandatory service period.

''(3) RECAPTURE EVENT DEFINED.—

''(A) IN GENERAL.—For purposes of this subsection, the term 'recapture event' means

the failure of the taxpayer to be a qualified primary health services provider for any month during the taxpayer's mandatory service period.

''(B) SECRETARIAL WAIVER.—The Secretary, in consultation with the Secretary of Health and Human Services, may waive any recapture event caused by extraordinary circumstances.

''(4) NO CREDITS AGAINST TAX; MINIMUM TAX.—Any increase in tax under this subsection shall not be treated as a tax imposed by this chapter for purposes of determining the amount of any credit under subpart A, B, or D of this part or for purposes of section 55.''

(b) CLERICAL AMENDMENT.—The table of sections for subpart A of part IV of subchapter A of chapter 1 of such Code is amended by inserting after the item relating to section 22 the following new item:

''Sec. 23. Primary health services providers.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1994.

SEC. 342. EXPENSING OF MEDICAL EQUIPMENT.

(a) IN GENERAL.—Paragraph (1) of section 179(b) of the Internal Revenue Code of 1986 (relating to dollar

limitation on expensing of certain depreciable business assets) is amended to read as follows:

''(1) DOLLAR LIMITATION.—

''(A) GENERAL RULE.—The aggregate cost which may be taken into account under subsection (a) for any taxable year shall not exceed $17,500.

''(B) HEALTH CARE PROPERTY.—The aggregate cost which may be taken into account under subsection (a) shall be increased by the lesser of—

''(i) the cost of section 179 property which is health care property placed in service during the taxable year, or

''(ii) $10,000.''

(b) DEFINITION.—Section 179(d) of such Code (relating to definitions) is amended by adding at the end the following new paragraph:

''(11) HEALTH CARE PROPERTY.—For purposes of this section, the term 'health care property' means section 179 property—

''(A) which is medical equipment used in the screening, monitoring, observation, diagnosis, or treatment of patients in a laboratory, medical, or hospital environment,

''(B) which is owned (directly or indirectly) and used by a physician (as defined in section 1861(r) of the Social Security Act) in the active conduct of such physician's full-time trade or business of providing primary health services (as defined in section 330(b)(1) of the Public Health Service Act) in a health professional shortage area (as defined in section 332(a)(1)(A) of the Public Health Service Act), and

''(C) substantially all the use of which is in such area.''

(c) RECAPTURE.—Paragraph (10) of section 179(d) of such Code is amended by inserting before the period ''and with respect to any health care property which ceases (other than by an area failing to be treated as a health professional shortage area) to be health care property at any time''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to property placed in service in taxable years beginning after December 31, 1994.

SEC. 343. EXPANDED SERVICES FOR MEDICALLY UNDERSERVED INDIVIDUALS.

(a) IN GENERAL.—Subpart I of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.)

(as amended by section 313) is amended by adding at the end the following new section:

"SEC. 330B. EXPANDED SERVICES FOR MEDICALLY UNDERSERVED INDIVIDUALS.

''(a) ESTABLISHMENT OF HEALTH SERVICES ACCESS PROGRAM.—From amounts appropriated under this section, the Secretary shall, acting through the Bureau of Health Care Delivery Assistance, award grants under this section to federally qualified health centers (hereinafter referred to in this section as 'FQHC's') and other entities and organizations submitting applications under this section (as described in subsection (c)) for the purpose of providing access to services for medically underserved populations (as defined in section 330(b)(3)) or in high impact areas (as defined in section 329(a)(5)) not currently being served by a FQHC.

''(b) ELIGIBILITY FOR GRANTS.—

''(1) IN GENERAL.—The Secretary shall award grants under this section to entities or organizations described in this paragraph and paragraph (2) which have submitted a proposal to the Secretary to expand such entities or organizations operations (including expansions to new sites (as determined necessary by the Secretary)) to serve medically under-

served populations or high impact areas not currently served by a FQHC and which—

''(A) have as of January 1, 1991, been certified by the Secretary as a FQHC under section 1905(l)(2)(B) of the Social Security Act; or

''(B) have submitted applications to the Secretary to qualify as FQHC's under such section 1905(l)(2)(B); or

''(C) have submitted a plan to the Secretary which provides that the entity will meet the requirements to qualify as a FQHC when operational.

''(2) NON FQHC ENTITIES.—

''(A) ELIGIBILITY.—The Secretary shall also make grants under this section to public or private nonprofit agencies, health care entities or organizations which meet the requirements necessary to qualify as a FQHC except, the requirement that such entity have a consumer majority governing board and which have submitted a proposal to the Secretary to provide those services provided by a FQHC as defined in section 1905(l)(2)(B) of the Social Security Act and which are designed to promote access

to primary care services or to reduce reliance on hospital emergency rooms or other high cost providers of primary health care services, provided such proposal is developed by the entity or organizations (or such entities or organizations acting in a consortium in a community) with the review and approval of the Governor of the State in which such entity or organization is located.

''(B) LIMITATION.—The Secretary shall provide in making grants to entities or organizations described in this paragraph that no more than 10 percent of the funds provided for grants under this section shall be made available for grants to such entities or organizations.

''(c) APPLICATION REQUIREMENTS.—

''(1) IN GENERAL.—In order to be eligible to receive a grant under this section, a FQHC or other entity or organization must submit an application in such form and at such time as the Secretary shall prescribe and which meets the requirements of this subsection.

''(2) REQUIREMENTS.—An application submitted under this section must provide—

''(A)(i) for a schedule of fees or payments for the provision of the services provided by the entity designed to cover its reasonable costs of operations; and

''(ii) for a corresponding schedule of discounts to be applied to such fees or payments, based upon the patient's ability to pay (determined by using a sliding scale formula based on the income of the patient);

''(B) assurances that the entity or organization provides services to persons who are eligible for benefits under title XVIII of the Social Security Act, for medical assistance under title XIX of such Act or for assistance for medical expenses under any other public assistance program or private health insurance program; and

''(C) assurances that the entity or organization has made and will continue to make every reasonable effort to collect reimbursement for services—

''(i) from persons eligible for assistance under any of the programs described in subparagraph (B); and

''(ii) from patients not entitled to benefits under any such programs.

''(d) LIMITATIONS ON USE OF FUNDS.—

''(1) IN GENERAL.—From the amounts awarded to an entity or organization under this section, funds may be used for purposes of planning but may only be expended for the costs of—

''(A) assessing the needs of the populations or proposed areas to be served;

''(B) preparing a description of how the needs identified will be met; and

''(C) development of an implementation plan that addresses—

''(i) recruitment and training of personnel; and

''(ii) activities necessary to achieve operational status in order to meet FQHC requirements under 1905(l)(2)(B) of the Social Security Act.

''(2) RECRUITING, TRAINING AND COMPENSATION OF STAFF.—From the amounts awarded to an entity or organization under this section, funds may be used for the purposes of paying for the costs of recruiting, training and compensating staff (clinical and associated administrative personnel (to the extent such costs are not already reimbursed under title XIX of the Social Security Act or any other

State or Federal program)) to the extent necessary to allow the entity to operate at new or expended existing sites.

''(3) FACILITIES AND EQUIPMENT.—From the amounts awarded to an entity or organization under this section, funds may be expended for the purposes of acquiring facilities and equipment but only for the cost of—

''(A) construction of new buildings (to the extent that new construction is found to be the most cost-efficient approach by the Secretary);

''(B) acquiring, expanding, and modernizing of existing facilities;

''(C) purchasing essential (as determined by the Secretary) equipment; and

''(D) amortization of principal and payment of interest on loans obtained for purposes of site construction, acquisition, modernization, or expansion, as well as necessary equipment.

''(4) SERVICES.—From the amounts awarded to an entity or organization under this section, funds may be expanded for the payment of services but only for the costs of—

''(A) providing or arranging for the provision of all services through the entity necessary

to qualify such entity as a FQHC under section 1905(l)(2)(B) of the Social Security Act;

''(B) providing or arranging for any other service that a FQHC may provide and be reimbursed for under title XIX of such Act; and

''(C) providing any unreimbursed costs of providing services as described in section 330(a) to patients.

''(e) PRIORITIES IN THE AWARDING OF GRANTS.—

''(1) CERTIFIED FQHC's.—The Secretary shall give priority in awarding grants under this section to entities which have, as of January 1, 1991, been certified as a FQHC under section 1905(l)(2)(B) of the Social Security Act and which have submitted a proposal to the Secretary to expand their operations (including expansion to new sites) to serve medically underserved populations for high impact areas not currently served by a FQHC. The Secretary shall give first priority in awarding grants under this section to those FQHCs or other entities which propose to serve populations with the highest degree of unmet need, and which can demonstrate the ability to expand their operations in the most efficient manner.

''(2) QUALIFIED FQHC's.—The Secretary shall give second priority in awarding grants to entities which have submitted applications to the Secretary which demonstrate that the entity will qualify as a FQHC under section 1905(l)(2)(B) of the Social Security Act before it provides or arranges for the provision of services supported by funds awarded under this section, and which are serving or proposing to serve medically underserved populations or high impact areas which are not currently served (or proposed to be served) by a FQHC.

''(3) EXPANDED SERVICES AND PROJECTS.—The Secretary shall give third priority in awarding grants in subsequent years to those FQHCs or other entities which have provided for expanded services and project and are able to demonstrate that such entity will incur significant unreimbursed costs in providing such expanded services.

''(f) RETURN OF FUNDS TO SECRETARY FOR COSTS REIMBURSED FROM OTHER SOURCES.—To the extent that an entity or organization receiving funds under this section is reimbursed from another source for the provision of services to an individual, and does not use such increased reimbursement to expand services furnished, areas served, to compensate for costs of unreimbursed

services provided to patients, or to promote recruitment, training, or retention of personnel, such excess revenues shall be returned to the Secretary.

''(g) TERMINATION OF GRANTS.—

''(1) FAILURE TO MEET FQHC REQUIREMENTS.—

''(A) IN GENERAL.—With respect to any entity that is receiving funds awarded under this section and which subsequently fails to meet the requirements to qualify as a FQHC under section 1905(l)(2)(B) or is an entity that is not required to meet the requirements to qualify as a FQHC under section 1905(l)(2)(B) of the Social Security Act but fails to meet the requirements of this section, the Secretary shall terminate the award of funds under this section to such entity.

''(B) NOTICE.—Prior to any termination of funds under this section to an entity, the entities shall be entitled to 60 days prior notice of termination and, as provided by the Secretary in regulations, an opportunity to correct any deficiencies in order to allow the entity to continue to receive funds under this section.

''(2) REQUIREMENTS.—Upon any termination of funding under this section, the Secretary may (to the extent practicable)—

''(A) sell any property (including equipment) acquired or constructed by the entity using funds made available under this section or transfer such property to another FQHC, provided, that the Secretary shall reimburse any costs which were incurred by the entity in acquiring or constructing such property (including equipment) which were not supported by grants under this section; and

''(B) recoup any funds provided to an entity terminated under this section.

''(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $100,000,000 for each of the fiscal years 1996 through 1999.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall become effective with respect to services furnished by a federally qualified health center or other qualifying entity described in this section beginning on or after October 1, 1995.

SEC. 344. ACCUMULATION OF RESERVES BY CERTAIN ENTITIES.

Any organization referred to in section 329, 330, or 340 of the Public Health Service Act may accumulate reserves.

SEC. 345. MATERNAL AND INFANT CARE COORDINATION.

(a) PURPOSE.—It is the purpose of this section to assist States in the development and implementation of coordinated, multidisciplinary, and comprehensive primary health care and social services, and health and nutrition education programs, designed to improve maternal and child health.

(b) GRANTS FOR IMPLEMENTATION OF PROGRAMS.—

(1) AUTHORITY.—The Secretary of Health and Human Services (hereafter referred to in this section as the ''Secretary'') is authorized to award grants to States to enable such States to plan and implement coordinated, multidisciplinary, and comprehensive primary health care and social service programs targeted to pregnant women and infants.

(2) ELIGIBILITY.—To be eligible to receive a grant under this section, a State shall—

(A) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

(B) as part of the State application, provide assurances that under the program established with amounts received under a grant, individuals will have access to a broad range of primary health care services, social services, and health and nutrition programs designed to improve maternal and child health and a description of how coordination of such services will improve maternal and child health based upon the goals of ''Healthy People 2000: National Health Promotion and Disease Prevention Objectives'';

(C) as part of the State application, submit a plan for the coordination of existing and proposed Federal and State resources, as appropriate, including amounts provided under the medicaid program under title XIX of the Social Security Act, the special supplemental food program under section 17 of the Child Nutrition Act of 1966, family planning programs, substance abuse programs, State maternal and child health programs funded under title V of the Social Security Act, community and migrant health center programs under the Public

Health Service Act, and other publicly, or where practicable, privately supported programs;

(D) demonstrate that the major service providers to be involved, including private non-profit entities committed to improving maternal and infant health, are committed to and involved in the program to be funded with amounts received under the grant;

(E) with respect to States with high infant mortality rates among minority populations, demonstrate the involvement of major health, multiservice, professional, or civic group representatives of such minority groups in the planning and implementation of the State program; and

(F) demonstrate that activities under the State program are targeted to women of childbearing age, particularly those at risk for having low birth weight babies.

(3) TERM OF GRANT.—A grant awarded under this subsection shall be for a period of 5 years.

(4) USE OF AMOUNTS.—Amounts received by a State under a grant awarded under this subsection shall be used to establish a State program to provide coordinated, multidisciplinary, and comprehensive

primary health care and social services, and health and nutrition education program services, that are designed to improve maternal and child health. Such amounts shall not be used for the construction of buildings or the purchase of medical equipment.

(5) MAINTENANCE OF EFFORT.—Any funds received by a State under this subsection shall supplement, and shall not supplant, funds that are expended for similar purposes by the State.

(6) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this subsection for fiscal years 1995 through 1998.

SEC. 346. PRE-SCHOOL AND ELEMENTARY SCHOOL HEALTH EDUCATION PROGRAMS.

Section 4605 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 3155) is amended to read as follows:

"SEC. 4605. PRE-SCHOOL AND ELEMENTARY SCHOOL HEALTH EDUCATION PROGRAMS.

''(a) PURPOSE.—It is the purpose of this section to establish a comprehensive school health education and prevention program for pre-school and elementary school students.

''(b) PROGRAM AUTHORIZED.—The Secretary shall award grants to States to enable such States to—

''(1) award grants to local or intermediate educational agencies, and consortia thereof, to enable such agencies or consortia to establish, operate and improve local programs of comprehensive health education and prevention, early health intervention, and health education, in pre-school and elementary schools; and

''(2) develop training, technical assistance and coordination activities for the programs assisted pursuant to paragraph (1).

''(c) USE OF FUNDS.—Grant funds under this section may be used to improve pre-school and elementary school education in the areas of—

''(1) personal health and fitness;

''(2) prevention of chronic diseases;

''(3) prevention and control of communicable diseases;

''(4) nutrition;

''(5) substance use and abuse;

''(6) accident prevention and safety;

''(7) community and environmental health;

''(8) mental and emotional health; and

''(9) the effective use of the health services delivery system.

''(d) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this section for fiscal years 1996 through 2000.

''(2) AVAILABILITY.—Funds appropriated pursuant to the authority of paragraph (1) in any fiscal year shall remain available for obligation and expenditure until the end of the fiscal year succeeding the fiscal year for which such funds were appropriated.''.

SEC. 347. FRONTIER STATES.

(a) IN GENERAL.—Frontier States (including Alaska, Wyoming and Montana) may implement proposals to offer preventive services, including mobile preventive health centers which may include centers equipped with various preventive health services, such as mammography, eye care, X-ray, and other advanced equipment, and which may be located on aircraft, watercraft, or other forms of transportation.

(b) DEMONSTRATION PROJECTS.—Frontier States may participate in demonstration projects under this or any other Act to improve recruitment, retention, and

training of rural providers, including nurse practitioners and physician assistants. Such demonstration projects shall give special consideration to the diverse needs of Frontier States, and shall involve cooperative agreements with a range of service delivery systems and teaching hospitals.

SEC. 348. INCREASE IN NATIONAL HEALTH SERVICE CORPS AND AREA HEALTH EDUCATION CENTER FUNDING.

(a) NATIONAL HEALTH SERVICE CORPS.—Section 338H(b)(1) of the Public Health Service Act (42 U.S.C. 254q(b)(1)) is amended—

(1) by striking ''1991, and'' and inserting ''1991,''; and

(2) by striking ''through 2000'' and inserting '', 1993, and 1994, and $20,000,000 for each of the fiscal years 1995 through 2000''.

(b) AREA HEALTH EDUCATION CENTERS.—Section 746(i)(1) of such Act (42 U.S.C. 293j(i)(1)) is amended—

(1) in subparagraph (A), by striking ''1995'' and inserting ''1995, and $20,000,000 for each of the fiscal years 1996 through 2000''; and

(2) in subparagraph (C), by striking ''and 1995'' and inserting ''1995, and $20,000,000 for each of the fiscal years 1996 through 2000''.

SEC. 349. TELEMEDICINE FEDERAL INTERAGENCY TASK FORCE.

(a) ESTABLISHMENT.—Not later than 90 days after the date of the enactment of this section, the Secretary of Health and Human Services shall establish a Federal interagency task force to be known as the 'Interagency Task Force on Rural Telemedicine' (hereafter in this section referred to as the ''Task Force'').

(b) DUTIES.—

(1) IN GENERAL.—The Task Force shall—

(A) identify specific uses for telemedicine that have been proven to be effective to be used in the evaluation of applications for federally funded telemedicine demonstration projects, including any application submitted under this part;

(B) review and coordinate evaluations of all federally funded telemedicine and telecommunications infrastructure demonstration projects, including any demonstration project established under this subtitle;

(C) establish mechanisms to facilitate a local area needs assessment and consortium development process to assist entities conducting federally funded telemedicine demonstration

projects, including demonstration projects under this part; and

(D) review the provision of telemedicine services under the demonstration projects established under section 350.

(2) PUBLICATION OF RESULTS.—Not later than 2 years after the Task Force is established, and annually thereafter, the Task Force shall analyze and publish a report of its findings under subparagraphs (A) through (D) of paragraph (1) and shall make such publications available to the Congress and the general public.

(c) MEMBERSHIP.—

(1) IN GENERAL.—The Task Force shall consist of representatives of—

(A) the Department of Health and Human Services;

(B) the Rural Electrification Administration;

(C) the National Telecommunications Information Agency;

(D) the National Institutes of Health; and

(E) other agencies and departments that have responsibility for overseeing telemedicine projects.

(2) CHAIRPERSON.—A representative of the Department of Health and Human Services shall serve as the chairperson of the Task Force.

(d) BASIC PAY.—Each member of the Task Force shall serve without pay.

(e) MEETINGS.—The Task Force shall meet at the call of the chairperson.

(f) QUORUM.—A majority of the members shall constitute a quorum for the transaction of business.

SEC. 350. DEMONSTRATION PROJECTS TO PROMOTE TELEMEDICINE.

(a) DEFINITIONS.—For purposes of this section:

(1) RURAL HEALTH CARE PROVIDER.—The term ''rural health care provider'' means any public or private health care provider located in a rural area.

(2) NONHEALTH CARE ENTITY.—The term ''nonhealth care entity'' means any entity that is not involved in the provision of health care, including a business, educational institution, library, and prison.

(b) ESTABLISHMENT.—The Secretary, acting through the Office of Rural Health, shall award grants to eligible entities to establish demonstration projects under which an eligible entity establishes a rural-based

consortium that enables members of the consortium to utilize the telecommunications network—

(1) to strengthen the delivery of health care services in the rural area through the use of telemedicine;

(2) to provide for consultations involving transmissions of detailed data about the patient that serves as a reasonable substitute for face-to-face interaction between the patient and consultant; and

(3) to make outside resources or business interaction more available to the rural area.

(c) ELIGIBLE ENTITY.—To be eligible to receive a grant under this section an applicant entity shall propose a consortium that includes as members at least—

(1) one rural health care provider; and

(2) one nonhealth care entity located in the same rural area as the rural health care provider described in paragraph (1).

The Secretary may waive the membership requirement under paragraph (2) if the members described in paragraph (1) are unable to locate a nonhealth care entity located in the same rural area to participate in the demonstration project.

(d) APPLICATION.—To be eligible to receive a grant under this section, an eligible entity described in sub-

section (c) shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the use to which the eligible entity would apply any amounts received under such grant, the source and amount of non-Federal funds the entity would pledge for the project, and a showing of the long-term sustainability of the project.

(e) GRANTS.—Grants under this section shall be distributed in accordance with the following requirements:

(1) GRANT LIMIT.—The Secretary may not make a grant to an eligible entity under this section in excess of $500,000 for each fiscal year in which an eligible entity conducts a project under this section.

(2) MATCHING FUNDS.—

(A) IN GENERAL.—The Secretary may not make a grant to an eligible entity under this section unless the eligible entity agrees to provide non-Federal funds in an amount equal to not less than 20 percent of the total amount to be expended by the eligible entity in any fiscal year for the purpose of conducting the project under this section.

(B) ADJUSTMENTS.—The Secretary shall make necessary adjustments to the amount that an eligible entity may receive in a subsequent fiscal year if the eligible entity does not meet the requirements of subparagraph (A) in the preceding fiscal year.

(f) USE OF GRANT AMOUNTS.—

(1) IN GENERAL.—Amounts received under a grant awarded under this section shall be utilized for the development and operation of telemedicine systems that serve rural areas. All such grant funds must be used to further the provision of health services to rural areas.

(2) RULES OF USE.—

(A) PERMISSIBLE USAGES.—Grant funds awarded under this section—

(i) shall primarily be used to support the costs of establishing and operating a telemedicine system that provides specialty consultations to rural communities;

(ii) may be used to demonstrate the application of telemedicine for preceptorship of medical students, residents, and other health professions students in rural training sites;

(iii) may be used for transmission costs, salaries, maintenance of equipment, and compensation of specialists and referring practitioners;

(iv) may be used to pay the fees of consultants, but only to the extent that the total of such fees do not exceed 5 percent of the amount of the grant;

(v) may be used to demonstrate the use of telemedicine to facilitate collaboration between non-physician primary care practitioners (including physician assistants, nurse practitioners, certified nurse-midwives, and clinical nurse specialists) and physicians; and

(vi) may be used to test reimbursement methodologies under the medicare program under title XVIII of the Social Security Act and the medicaid program under title XIX of such Act for practitioners participating in telemedicine activities.

(B) PROHIBITED USE OF FUNDS.—Grant funds shall not be used by members of a rural-based consortium for any of the following:

(i) Expenditures to purchase or lease equipment.

(ii) In the case of a member of a consortium that is an isolated rural facility, purchase of high-cost telecommunications technologies for the furnishing of telemedicine services that—

(I) incur high cost per minute of usage charges; or

(II) require consultants to be available at the same time as the patient and the referring physician.

(iii) Purchase or installation of transmission equipment or establishment or operation of a telecommunications common carrier network.

(iv) Expenditures for indirect costs (as determined by the Secretary) to the extent the expenditures would exceed more than 20 percent of the total grant funds.

(v) Construction (except for minor renovations related to the installation of equipment), or the acquisition or building of real property.

(g) MAINTENANCE OF EFFORT.—Any funds available for the activities covered by a demonstration project conducted under this section shall supplement, and shall not supplant, funds that are expended for similar purposes under any State, regional, or local program.

(h) EVALUATIONS.—Each eligible entity that conducts a demonstration project under this section shall submit to the Secretary such information and interim evaluations as the Secretary may require. The Secretary shall provide the Interagency Task Force on Rural Telemedicine with such evaluations and information submitted under the previous sentence as the Task Force may required to carry out its duties under section 345(b).

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $10,000,000 for each of the fiscal years 1995 through 1997.

Subtitle E—Payment Flexibility

SEC. 351. ESSENTIAL ACCESS COMMUNITY HOSPITAL (EACH) AMENDMENTS.

(a) UNLIMITED PARTICIPATING STATES; ELIMINATION OF GRANT TIE-IN.—

(1) IN GENERAL.—Section 1820(a) of the Social Security Act (42 U.S.C. 1395i–4(a)) is amended to read as follows:

''(a) IN GENERAL.—

''(1) PROGRAM DESCRIBED.—There is hereby established a program under which the Secretary—

''(A) shall permit States that have submitted an application in accordance with subsection (b) to carry out the activities described in subsections (e) and (f); and

''(B) shall designate (under subsection (i)) hospitals and facilities located in States participating in a program under this section as essential access community hospitals or rural primary care hospitals.

''(2) AVAILABILITY OF GRANTS.—

''(A) STATES.—The Secretary shall make grants available to selected States described in paragraph (1)(A) to carry out the activities described in subsection (d)(1).

''(B) ELIGIBLE HOSPITALS AND FACILITIES.—The Secretary shall make grants available to selected eligible hospitals and facilities (or consortia of hospitals and facilities) to carry out the activities described in subsection (d)(2).''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1820(b) of such Act (42 U.S.C. 1395i–4(b)) is amended by striking ''ELIGIBILITY OF STATES FOR GRANTS.—'' through ''subsection (a)(1)'' and inserting ''APPLICATION.—A State is eligible to participate in the program described in this section''.

(B) Section 1820(c) of such Act (42 U.S.C. 1395i–4(c)) is amended—

(i) in paragraph (1)—

(I) in the matter preceding subparagraph (A), by striking ''(a)(2)'' and inserting ''(a)(2)(B)'', and

(II) in subparagraph (A), by striking ''receiving a grant under subsection (a)(1)'' and inserting ''participating in the program under this section''; and

(ii) in paragraph (3)—

(I) by striking ''STATE RECEIVING GRANT.—'' and inserting ''STATE PARTICIPATING IN THE PROGRAM.—'', and

(II) by striking ''(a)(2)'' and inserting ''(a)(2)(B)''.

(C) Section 1820(d) of such Act (42 U.S.C. 1395i–4(d)) is amended—

(i) in paragraph (1), by striking ''(a)(1)'' and inserting ''(a)(2)(A)''; and

(ii) in paragraph (2), by striking ''(a)(2)'' each place it appears and and inserting ''(a)(2)(B)''.

(C) Section 1820(i) of such Act (42 U.S.C. 1395i–4(i)) is amended—

(i) in paragraph (1)(A)(i), by striking ''receiving a grant under subsection (a)(1)'' and inserting ''participating in the program under this section''; and

(ii) in paragraph (2)(A)(i), by striking ''receiving a grant under subsection (a)(1)'' and inserting ''participating in the program under this section''.

(b) TREATMENT OF INPATIENT HOSPITAL SERVICES PROVIDED IN RURAL PRIMARY CARE HOSPITALS.—

(1) IN GENERAL.—Section 1820(f)(1)(F) of the Social Security Act (42 U.S.C. 1395i–4(f)(1)(F)) is amended to read as follows:

''(F) subject to paragraph (4), provides not more than 6 inpatient beds (meeting such conditions as the Secretary may establish) for pro-

viding inpatient care to patients requiring stabilization before discharge or transfer to a hospital, except that the facility may not provide any inpatient hospital services consisting of surgery or any other service requiring the use of general anesthesia (other than surgical procedures specified by the Secretary under section 1833(i)(1)(A)) unless the attending physician certifies that the risk associated with transferring the patient to a hospital for such services outweighs the benefits of transferring the patient to a hospital for such services.''.

(2) LIMITATION ON AVERAGE LENGTH OF STAY.—Section 1820(f) of such Act (42 U.S.C. 1395i–4(f)) is amended by adding at the end the following new paragraph:

''(4) LIMITATION ON AVERAGE LENGTH OF INPATIENT STAYS.—The Secretary may terminate a designation of a rural primary care hospital under paragraph (1) if the Secretary finds that the average length of stay for inpatients at the facility during the previous year in which the designation was in effect exceeded 72 hours. In determining the compliance of a facility with the requirement of the previous sentence, there shall not be taken into account

periods of stay of inpatients in excess of 72 hours to the extent such periods exceed 72 hours because transfer to a hospital is precluded because of inclement weather or other emergency conditions.''.

(3) CONFORMING AMENDMENT.—Section 1814(a)(8) of such Act (42 U.S.C. 1395f(a)(8)) is amended by striking ''such services'' and all that follows and inserting ''the individual may reasonably be expected to be discharged or transferred to a hospital within 72 hours after admission to the rural primary care hospital.''.

(4) GAO REPORTS.—Not later than 2 years after the date of the enactment of this Act, the Comptroller General shall submit reports to Congress on—

(A) the application of the requirement under section 1820(f) of the Social Security Act (as amended by this subsection) that rural primary care hospitals maintain an average length of inpatient stay during a year that does not exceed 72 hours; and

(B) the extent to which such requirement has resulted in such hospitals providing inpatient care beyond their capabilities or have lim-

ited the ability of such hospitals to provide needed services.

(c) DESIGNATION OF HOSPITALS.—

(1) PERMITTING DESIGNATION OF HOSPITALS LOCATED IN URBAN AREAS.—

(A) IN GENERAL.—Section 1820 of the Social Security Act (42 U.S.C. 1395i–4) is amended—

(i) by striking paragraph (1) of subsection (e) and redesignating paragraphs (2) through (6) as paragraphs (1) through (5);

(ii) in subsection (e)(1)(A) (as redesignated by subparagraph (A))—

(I) by striking ''is located'' and inserting ''except in the case of a hospital located in an urban area, is located'',

(II) by striking '', (ii)'' and inserting ''or (ii)'', and

(III) by striking ''or (iii)'' and all that follows through ''section,''; and

(iii) in subsection (i)(1)(B), by striking ''paragraph (3)'' and inserting ''paragraph (2)''.

(B) NO CHANGE IN MEDICARE PROSPECTIVE PAYMENT.—Section 1886(d)(5)(D) of such Act (42 U.S.C. 1395ww(d)(5)(D)) is amended—

(i) in clause (iii)(III), by inserting ''located in a rural area and'' after ''that is'', and

(ii) in clause (v), by inserting ''located in a rural area and'' after ''in the case of a hospital''.

(2) PERMITTING HOSPITALS LOCATED IN ADJOINING STATES TO PARTICIPATE IN STATE PROGRAM.—

(A) IN GENERAL.—Section 1820 of such Act (42 U.S.C. 1395i–4) is amended—

(i) by redesignating subsection (k) as subsection (l); and

(ii) by inserting after subsection (j) the following new subsection:

''(k) ELIGIBILITY OF HOSPITALS NOT LOCATED IN PARTICIPATING STATES.—Notwithstanding any other provision of this section—

''(1) for purposes of including a hospital or facility as a member institution of a rural health network, a State may designate a hospital or facility

that is not located in the State as an essential access community hospital or a rural primary care hospital if the hospital or facility is located in an adjoining State and is otherwise eligible for designation as such a hospital;

''(2) the Secretary may designate a hospital or facility that is not located in a State receiving a grant under subsection (a)(1) as an essential access community hospital or a rural primary care hospital if the hospital or facility is a member institution of a rural health network of a State receiving a grant under such subsection; and

''(3) a hospital or facility designated pursuant to this subsection shall be eligible to receive a grant under subsection (a)(2).''.

(B) CONFORMING AMENDMENTS.—(i) Section 1820(c)(1) of such Act (42 U.S.C. 1395i–4(c)(1)) is amended by striking ''paragraph (3)'' and inserting ''paragraph (3) or subsection (k)''.

(ii) Paragraphs (1)(A) and (2)(A) of section 1820(i) of such Act (42 U.S.C. 1395i–4(i)) are each amended—

(I) in clause (i), by striking ''(a)(1)'' and inserting ''(a)(1) (except as provided in subsection (k))'', and

(II) in clause (ii), by striking ''subparagraph (B)'' and inserting ''subparagraph (B) or subsection (k)''.

(d) SKILLED NURSING SERVICES IN RURAL PRIMARY CARE HOSPITALS.—Section 1820(f)(3) of the Social Security Act (42 U.S.C. 1395i–4(f)(3)) is amended by striking ''because the facility'' and all that follows and inserting the following: ''because, at the time the facility applies to the State for designation as a rural primary care hospital, there is in effect an agreement between the facility and the Secretary under section 1883 under which the facility's inpatient hospital facilities are used for the furnishing of extended care services, except that the number of beds used for the furnishing of such services may not exceed the total number of licensed inpatient beds at the time the facility applies to the State for such designation (minus the number of inpatient beds used for providing inpatient care pursuant to paragraph (1)(F)). For purposes of the previous sentence, the number of beds of the facility used for the furnishing of extended care services shall not include any beds of a unit of the facility that is licensed as a distinct-part skilled nursing facility at the

time the facility applies to the State for designation as a rural primary care hospital.''.

(e) DEADLINE FOR DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—Section 1814(l)(2) of the Social Security Act (42 U.S.C. 1395f(l)(2)) is amended by striking ''January 1, 1993'' and inserting ''January 1, 1996''.

(f) PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—

(1) IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—Section 1834(g) of the Social Security Act (42 U.S.C. 1395m(g)) is amended—

(A) in paragraph (1), by striking ''during a year before 1993'' and inserting ''during a year before the prospective payment system described in paragraph (2) is in effect''; and

(B) in paragraph (2), by striking ''January 1, 1993,'' and inserting ''January 1, 1996,''.

(2) NO USE OF CUSTOMARY CHARGE IN DETERMINING PAYMENT.—Section 1834(g)(1) of such Act (42 U.S.C. 1395m(g)(1)) is amended by adding at the end the following new flush sentence:

''The amount of payment shall be determined under either method without regard to the amount of the customary or other charge.''.

(g) CLARIFICATION OF PHYSICIAN STAFFING REQUIREMENT FOR RURAL PRIMARY CARE HOSPITALS.—Section 1820(f)(1)(H) of the Social Security Act (42 U.S.C. 1395i–4(f)(1)(H)) is amended by striking the period and inserting the following: '', except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1861(r)(1).''.

(h) TECHNICAL AMENDMENTS RELATING TO PART A DEDUCTIBLE, COINSURANCE, AND SPELL OF ILLNESS.—(1) Section 1812(a)(1) of the Social Security Act (42 U.S.C. 1395d(a)(1)) is amended—

(A) by striking ''inpatient hospital services'' the first place it appears and inserting ''inpatient hospital services or inpatient rural primary care hospital services'';

(B) by striking ''inpatient hospital services'' the second place it appears and inserting ''such services''; and

(C) by striking ''and inpatient rural primary care hospital services''.

(2) Sections 1813(a) and 1813(b)(3)(A) of such Act (42 U.S.C. 1395e(a), 1395e(b)(3)(A)) are each amended by striking ''inpatient hospital services'' each place it appears and inserting ''inpatient hospital services or inpatient rural primary care hospital services''.

(3) Section 1813(b)(3)(B) of such Act (42 U.S.C. 1395e(b)(3)(B)) is amended by striking ''inpatient hospital services'' and inserting ''inpatient hospital services, inpatient rural primary care hospital services''.

(4) Section 1861(a) of such Act (42 U.S.C. 1395x(a)) is amended—

(A) in paragraph (1), by striking ''inpatient hospital services'' and inserting ''inpatient hospital services, inpatient rural primary care hospital services''; and

(B) in paragraph (2), by striking ''hospital'' and inserting ''hospital or rural primary care hospital''.

(i) AUTHORIZATION OF APPROPRIATIONS.—Section 1820(e) of the Social Security Act (42 U.S.C. 1395i–4(e)), as redesignated by subsection (c)(2)(A), is amended—

(1) in the matter preceding paragraph (1), by striking ''1990, 1991, and 1992'' and inserting ''1990 through 1998'';

(2) in paragraph (1), by striking ''$10,000,000'' and ''(a)(1)'' and inserting ''$30,000,000'' and ''(a)(2)(A)'', respectively; and

(3) in paragraph (2), by striking ''$15,000,000'' and ''(a)(2)'' and inserting ''$45,000,000'' and ''(a)(2)(B)'', respectively.

(j) NO LIMITATION ON NUMBER OF RURAL PRIMARY CARE HOSPITALS IN NON-EACH STATES.—Section 1820(i)(2)(C) of the Social Security Act (42 U.S.C. 1395i–4(i)(2)(C)) is amended—

(1) by striking ''15''; and

(2) by striking ''(f)(1), except that nothing'' and inserting ''(f)(1) and establishes a relationship with a full-service rural hospital that meets the requirements described in paragraph (1) through (6) of subsection (e), except that such hospital need not meet the 75 bed requirement described in paragraph (3) of such subsection. Nothing''.

(k) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 352. DEMONSTRATION PROJECTS TO IMPROVE ACCESS IN RURAL AREAS.

(a) IN GENERAL.—Part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''DEMONSTRATION PROJECTS TO IMPROVE ACCESS IN RURAL AREAS

''SEC. 1821. (a) MEDICAL ASSISTANCE FACILITY DEMONSTRATION PROJECT.—

(1) ESTABLISHMENT.—The Secretary shall provide for the establishment of demonstration projects in States providing that medical assistance facilities located in such States may receive payment in accordance with paragraph (4).

''(2) APPLICATIONS.—

''(A) IN GENERAL.—Each State desiring to conduct a demonstrationproject under this subsection shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including an explanation of a plan for evaluating the project.

''(B) APPROVAL OF APPLICATIONS.—A State that submits an application under subparagraph (A) may begin a demonstration project under this subsection—

''(i) upon approval of such application by the Secretary; or

''(ii) at the end of the 60-day period beginning on the date such application is submitted, unless the Secretary denies the application during such period.

''(3) MEDICAL ASSISTANCE FACILITY.—The term 'medical assistance facility' means for a fiscal year, a facility with respect to which the Secretary finds the following:

''(A) The facility is located in a county (or equivalent unit of local government) with fewer than 6 residents per square mile or is located more than a 35 mile drive from a hospital, a rural primary care hospital, or another facility described in this subsection.

''(B) The facility furnishes services to ill or injured individuals prior to the transportation of such individuals to a hospital or furnishes inpatient care to individuals needing such care for a period not longer than 96 hours.

''(C) The facility permits a physician assistant or nurse practitioner to admit and treat patients under the supervision of a physician not present in such facility.

''(D) The facility meets the requirements of section 1861(e) that are applicable to a hospital located in a rural area except that—

''(i) with respect to any requirements relating to the number of hours that the facility must be open on a daily or weekly basis, the facility is only required to meet the requirement to provide emergency care on a 24-hour basis;

''(ii) with respect to any services required under such section to be furnished by a dietician, pharmacist, laboratory technician, medical technologist, and radiological technologist, the facility may furnish such services on a part-time, off-site basis; and

''(iii) the inpatient care described in subparagraph (B) may be furnished by a physician assistant or nurse practitioner as provided in subparagraph (C).

''(E) The facility receives a certification of medical necessity and appropriateness by a peer review organization (or the equivalent of a peer review organization) upon admitting each patient on an inpatient basis or, in the case of ad-

missions that do not occur during regular business hours, receives such a certification at the earliest possible time.

''(F) The facility may enter into an agreement with the Secretary under section 1883 under which the facility's inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute extended care services.

''(4) PAYMENT FOR SERVICES.—Each medical assistance facility located in a State participating in a demonstration project under this subsection shall receive payment for inpatient medical assistance facility services (as defined in section 1861(oo)(2)) in accordance with section 1814(m) and outpatient medical assistance facility services (as defined in section 1861(oo)(3)) in accordance with section 1834(i).

''(5) GRANTS.—The Secretary shall award grants to—

''(A) selected States participating in a demonstration project under this subsection for the purpose of assisting such States in promot-

ing the establishment of medical assistance facilities; and

''(B) selected facilities in States participating in a demonstration project under this section for the purpose of financing the costs a facility incurs in converting itself to a medical assistance facility.

''(6) MAINTENANCE OF EFFORT.—Any funds available for the activities covered by a demonstration project conducted under this subsection shall supplement, and shall not supplant, funds that are expended for similar purposes under any State, regional, or local program.

''(7) DURATION.—A demonstration project under this subsection shall be conducted for a period not to exceed 8 years.

''(8) EVALUATIONS AND REPORTS.—

''(A) EVALUATIONS.—Each State that conducts a demonstration project under this subsection shall submit to the Secretary a final evaluation of such project within 360 days of the termination of such project and such interim evaluations as the Secretary may require.

''(B) REPORTS TO CONGRESS.—Not later than 360 days after the first demonstration

project under this subsection begins, and annually thereafter for each year in which a project is conducted under this subsection, the Secretary shall submit a report to the appropriate committees of the Congress which evaluates the effectiveness of the demonstration projects conducted under this subsection and includes any legislative recommendations determined appropriate by the Secretary.

''(9) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for each of the fiscal years 1995 through 2000 from the Federal Hospital Insurance Trust Fund—

''(A) $20,000,000 for grants to States under paragraph (5)(A); and

''(B) $20,000,000 for grants to facilities under paragraph (5)(B).

''(b) RURAL EMERGENCY ACCESS CARE HOSPITAL DEMONSTRATION PROJECT.—

''(1) IN GENERAL.—

''(A) ESTABLISHMENT.—The Secretary shall provide for the establishment of demonstration projects in States providing that rural emergency access care hospitals located in such States may receive payment in accordance

with paragraph (5) for rural emergency access care hospital services provided to medicare beneficiaries.

''(2) APPLICATIONS.—

''(A) IN GENERAL.—Each State desiring to conduct a demonstration project under this subsection shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including an explanation of a plan for evaluating the project.

''(B) APPROVAL OF APPLICATIONS.—A State that submits an application under subparagraph (A) may begin a demonstration project under this subsection—

''(i) upon approval of such application by the Secretary; or

''(ii) at the end of the 60-day period beginning on the date such application is submitted, unless the Secretary denies the application during such period.

''(3) RURAL EMERGENCY ACCESS CARE HOSPITAL.—For purposes of this subsection, the term 'rural emergency access care hospital' means, for a

fiscal year, a facility with respect to which the Secretary finds the following:

''(A) The facility is located in a rural area (as defined in section 1886(d)(2)(D)).

''(B) The facility was a hospital under this title at any time during the 5-year period that ends on the date of the enactment of this subsection.

''(C) The facility is in danger of closing due to low inpatient utilization rates and negative operating losses, and the closure of the facility would limit the access of individuals residing in the facility's service area to emergency services.

''(D) The facility has entered into (or plans to enter into) an agreement with a hospital with a participation agreement in effect under section 1866(a), and under such agreement the hospital shall accept patients transferred to the hospital from the facility and receive data from and transmit data to the facility.

''(E) There is a practitioner who is qualified to provide advanced cardiac life support services (as determined by the State in which

the facility is located) on-site at the facility on a 24-hour basis.

''(F) A physician is available on-call to provide emergency medical services on a 24-hour basis.

''(G) The facility meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

''(i) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open, except insofar as the facility is required to provide emergency care on a 24-hour basis under subparagraphs (E) and (F); and

''(ii) the facility may provide any services otherwise required to be provided by a full-time, on-site dietician, pharmacist, laboratory technician, medical technologist, or radiological technologist on a part-time, off-site basis.

''(H) The facility meets the requirements applicable to clinics and facilities under subparagraphs (C) through (J) of paragraph (2) of

section 1861(aa) and of clauses (ii) and (iv) of the second sentence of such paragraph (or, in the case of the requirements of subparagraph (E), (F), or (J) of such paragraph, would meet the requirements if any reference in such subparagraph to a 'nurse practitioner' or to 'nurse practitioners' was deemed to be a reference to a 'nurse practitioner or nurse' or to 'nurse practitioners or nurses'), except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1861(r)(1).

''(4) RURAL EMERGENCY ACCESS CARE HOSPITAL SERVICES.—For purposes of this subsection, the term 'rural emergency access care hospital services' means the following services provided by a rural emergency access care hospital:

''(A) An appropriate medical screening examination (as described in section 1867(a)).

''(B) Necessary stabilizing examination and treatment services for an emergency medical condition and labor (as described in section 1867(b)).''.

''(5) PAYMENT FOR SERVICES.—Each rural emergency access care hospital located in a State participating in a demonstration project under this subsection shall receive payment for rural emergency access care hospital services in accordance with section 1833(a)(6).

''(6) GRANTS.—The Secretary shall award grants to—

''(A) selected States participating in a demonstration project under this subsection for the purpose of assisting such States in promoting the establishment of rural emergency access care hospitals; and

''(B) selected facilities in States participating in a demonstration project under this section for the purpose of financing the costs a facility incurs in converting itself to a rural emergency access care hospitals.

''(7) MAINTENANCE OF EFFORT.—Any funds available for the activities covered by a demonstration project conducted under this subsection shall supplement, and shall not supplant, funds that are expended for similar purposes under any State, regional, or local program.

''(8) DURATION.—A demonstration project under this subsection shall be conducted for a period not to exceed 8 years.

''(9) EVALUATIONS AND REPORTS.—

''(A) EVALUATIONS.—Each State that conducts a demonstration project under this subsection shall submit to the Secretary a final evaluation of such project within 360 days of the termination of such project and such interim evaluations as the Secretary may require.

''(B) REPORTS TO CONGRESS.—Not later than 360 days after the first demonstration project under this subsection begins, and annually thereafter for each year in which a project is conducted under this subsection, the Secretary shall submit a report to the appropriate committees of the Congress which evaluates the effectiveness of the demonstration projects conducted under this subsection and includes any legislative recommendations determined appropriate by the Secretary.

''(10) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for each of the fiscal years 1995 through 2000 from the Federal Hospital Insurance Trust Fund—

''(A) $20,000,000 for grants to States under paragraph (6)(A); and

''(B) $20,000,000 for grants to facilities under paragraph (6)(B).

(b) COVERAGE OF, AND PAYMENT FOR, MEDICAL ASSISTANCE FACILITY SERVICES.

(1) AMENDMENTS TO PART A.—

(A) DEFINITIONS.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Medical Assistance Facility; Medical Assistance Facility Services

''(oo)(1) The term 'medical assistance facility' means a facility which is located in a State that is participating in a demonstration project under section 1820(a) and for which the Secretary finds that the criteria described in subparagraphs (A) through (F) of section 1820(a) are met with respect to the facility.

(2) The term 'inpatient medical assistance facility services' means items and services furnished to an inpatient of a medical assistance facility by such facility that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.''.

(B) COVERAGE AND PAYMENT.—(i) Section 1812(a)(1) of such Act (42 U.S.C. 1395d(a)(1)) is amended by striking ''and inpatient rural primary care hospital services'' and inserting '', inpatient rural primary care hospital services, and inpatient medical assistance facility services''.

(ii) Section 1814 of such Act (42 U.S.C. 1395f) is amended—

(I) in subsection (a)—

(aa) by striking ''and'' at the end of paragraph (7),

(bb) by striking the period at the end of paragraph (8) and inserting ''; and'', and

(cc) by inserting after paragraph (8) the following new paragraph:

''(9) in the case of inpatient medical assistance facility services, a physician certifies that such services were required to be immediately furnished on a temporary, inpatient basis.'';

(ii) in subsection (b), by striking ''inpatient rural primary care hospital services,'' and inserting ''inpatient rural primary care hospital services, other than a medical assistance facility

providing inpatient medical assistance facility services,''; and

(III) by adding at the end the following new subsection:

''Payment for Inpatient Medical Assistance Facility Services

''(m) The amount of payment under this part for inpatient medical assistance facility services is the reasonable costs of the medical assistance facility in providing such services.''.

(C) TREATMENT OF MEDICAL ASSISTANCE FACILITIES AS PROVIDERS OF SERVICES.—(i) Section 1861(u) of such Act (42 U.S.C. 1395x(u)) is amended by inserting ''medical assistance facility,'' after ''rural primary care hospital,''.

(ii) The first sentence of section 1864(a) of such Act (42 U.S.C. 1395aa(a)) is amended by inserting ''a medical assistance facility, as defined in section 1861(oo)(1),'' after ''1861(mm)(1),''.

(iii) The third sentence of section 1865(a) of such Act (42 U.S.C. 1395bb(a)) is amended by striking ''or 1861(mm)(1)'' and inserting ''1861(mm)(1), or 1861(oo)(1),''.

(D) CONFORMING AMENDMENTS.—(i) Section 1128A(b)(1) of such Act (42 U.S.C. 1320a–7a(b)(1)) is amended—

(I) by striking ''or a rural primary care hospital'' the first place it appears and inserting '', a rural primary care hospital, or a medical assistance facility''; and

(II) by striking ''or a rural primary care hospital'' the second place it appears and inserting '', the rural primary care hospital, or the medical assistance facility''.

(ii) Section 1128B(c) of such Act (42 U.S.C. 1320a–7b(c)) is amended by inserting ''medical assistance facility,'' after ''rural primary care hospital,''.

(iii) Section 1134 of such Act (42 U.S.C. 1320b–4) is amended by striking ''or rural primary care hospitals'' each place it appears and inserting '', rural primary care hospitals, or medical assistance facilities''.

(iv) Section 1138(a)(1) of such Act (42 U.S.C. 1320b–8(a)(1)) is amended—

(I) in the matter preceding subparagraph (A), by striking ''or rural primary

care hospital'' and inserting '', rural primary care hospital, or medical assistance facility'', and

(II) in the matter preceding clause (i) of subparagraph (A), by striking ''or rural primary care hospital'' and inserting '', rural primary care hospital, or medical assistance facility''.

(v) Section 1164(e) of such Act (42 U.S.C. 1320c–13(e)) is amended by inserting ''medical assistance facilities,'' after ''rural primary care hospitals,''.

(vi) Section 1816(c)(2)(C) of such Act (42 U.S.C. 1395h(c)(2)(C)) is amended by inserting ''medical assistance facility,'' after ''rural primary care hospital,''.

(vii) Section 1833 of such Act (42 U.S.C. 1395l) is amended—

(I) in subsection (h)(5)(A)(iii)—

(aa) by striking ''or rural primary care hospital'' and inserting ''rural primary care hospital, or medical assistance facility''; and

(bb) by striking ''to the hospital'' and inserting ''to the hospital or the facility'';

(II) in subsection (i)(1)(A), by inserting ''medical assistance facility,'' after ''rural primary care hospital,'';

(III) in subsection (i)(3)(A), by striking ''or rural primary care hospital services'' and inserting ''rural primary care hospital services, or medical assistance facility services'';

(IV) in subsection (l)(5)(A), by inserting ''medical assistance facility,'' after ''rural primary care hospital,'' each place it appears; and

(V) in subsection (l)(5)(C), by striking ''or rural primary care hospital'' each place it appears and inserting '', rural primary care hospital, or medical assistance facility''.

(viii) Section 1835(c) of such Act (42 U.S.C. 1395n(c)) is amended by adding at the end the following: ''A medical assistance facility shall be considered a hospital for purposes of this subsection.''.

(ix) Section 1842(b)(6)(A)(ii) of such Act (42 U.S.C. 1395u(b)(6)(A)(ii)) is amended by inserting ''medical assistance facility,'' after ''rural primary care hospital,''.

(x) Section 1861 of such Act (42 U.S.C. 1395x) is amended—

(I) in the last sentence of subsection (e), by striking ''1861(mm)(1))'' and inserting ''1861(mm)(1)) or a medical assistance facility (as defined in section 1861(oo)(1)).'',

(II) in subsection (w)(1) by inserting ''medical assistance facility,'' after ''rural primary care hospital,'', and

(III) in subsection (w)(2), by striking ''or rural primary care hospital'' each place it appears and inserting '', rural primary care hospital, or medical assistance facility''.

(xi) Section 1862(a)(14) of such Act (42 U.S.C. 1395y(a)(14)) is amended by striking ''or rural primary care hospital'' each place it appears and inserting '', rural primary care hospital, or medical assistance facility''.

(xii) Section 1866(a)(1) of such Act (42 U.S.C 1395cc(a)(1)) is amended—

(I) in subparagraph (F)(ii), by inserting ''medical assistance facilities,'' after ''rural primary care hospitals,'';

(II) in subparagraph (H)—

(aa) in the matter preceding clause (i), by inserting ''and in the case of medical assistance facilities which provide inpatient medical assistance facility services'' after ''rural primary care hospital services''; and

(bb) in clauses (i) and (ii), by striking ''hospital'' each place it appears and inserting ''hospital or facility'';

(III) in subparagraph (I)—

(aa) in the matter preceding clause (i), by striking ''or rural primary care hospital'' and inserting '', a rural primary care hospital, or a medical assistance facility''; and

(bb) in clause (ii), by striking ''the hospital'' and inserting ''the hospital or the facility''; and

(IV) in subparagraph (N)—

(aa) in the matter preceding clause (i), by striking ''and rural primary hospitals'' and inserting '', rural primary care hospitals, and medical assistance facilities'';

(bb) in clause (i), by striking ''or rural primary care hospital,'' and inserting '', rural primary care hospital, or medical assistance facility,''; and

(cc) in clause (ii), by striking ''hospital'' and inserting ''hospital or facility''.

(xiii) Section 1866(a)(3) of such Act (42 U.S.C 1395cc(a)(3)) is amended—

(I) by striking ''rural primary care hospital,'' each place it appears in subparagraphs (A) and (B) and inserting ''rural primary care hospital, medical assistance facility,'', and

(II) in subparagraph (C)(ii)(II), by striking ''rural primary care hospitals,'' each place it appears and inserting ''rural primary care hospitals, medical assistance facilities''.

(xiv) Section 1867(e)(5) of such Act (42 U.S.C. 1395dd(e)(5)) is amended by striking ''1861(mm)(1))'' and inserting ''1861(mm)(1)) or a medical assistance facility (as defined in section 1861(oo)(1)).''.

(2) AMENDMENTS TO PART B.—

(A) COVERAGE.—(i) Section 1861(oo) of the Social Security Act (42 U.S.C. 1395x(oo)), as added by paragraph (1)(A), is amended by adding at the end the following new paragraph:

''(3) The term 'outpatient medical assistance facility services' means medical and other health services furnished by a medical assistance facility on an outpatient basis.''.

(ii) Section 1832(a)(2) of such Act (42 U.S.C. 1395k(a)(2)) is amended—

(I) in subparagraph (I), by striking ''and'' at the end;

(II) in subparagraph (J), by striking the period at the end and inserting ''; and''; and

(III) by adding at the end the following new subparagraph:

''(K) outpatient medical assistance facility services (as defined in section 1861(oo)(3)).''.

(B) PAYMENT.—(i) Section 1833(a) of such Act (42 U.S.C. 1395l(a)) is amended—

(I) in paragraph (2), in the matter preceding subparagraph (A), by striking ''and (I)'' and inserting ''(I), and (K)'';

(II) in paragraph (6), by striking ''and'' at the end;

(III) in paragraph (7), by striking the period at the end and inserting ''; and''; and

(IV) by adding at the end the following new paragraph:

''(8) in the case of outpatient medical assistance facility services, the amounts described in section 1834(i).''.

(ii) Section 1834 of such Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(i) PAYMENT FOR OUTPATIENT MEDICAL ASSISTANCE FACILITY SERVICES.—The amount of payment for outpatient medical assistance facility services provided in a medical assistance facility under this part shall be determined by one of the two following methods, as elected by the medical assistance facility:

''(1) COST-BASED FACILITY FEE PLUS PROFESSIONAL CHARGES.—

''(A) FACILITY FEE.—With respect to facility services, not including any services for which payment may be made under subparagraph (B), there shall be paid amounts equal to the amounts described in section 1833(a)(2)(B) (describing amounts paid for hospital outpatient services).

''(B) REASONABLE CHARGES FOR PROFESSIONAL SERVICES.—In electing treatment under this paragraph, payment for professional medical services otherwise included within outpatient medical assistance facility services shall be made under such other provisions of this part as would apply to payment for such services if they were not included in outpatient medical assistance facility services.

''(2) ALL-INCLUSIVE RATE.—

''(A) IN GENERAL.—With respect to both facility services and professional medical services, there shall be paid amounts equal to the excess of—

''(i) the costs which are reasonable and related to the cost of furnishing such

services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, over

''(ii) the amount the facility may charge as described in clause (i) of section 1866(a)(2)(A).

''(B) LIMITATION.—

''(i) IN GENERAL.—The payment amount determined under subparagraph (A) with respect to items and services shall not exceed 80 percent of the amount determined under clause (i) of such subparagraph with respect to such items and services.

''(ii) CERTAIN ITEMS AND SERVICES.—Clause (i) shall not apply to—

''(I) items and services described in section 1861(s)(10)(A), and

''(II) items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2), or third opinion, if the second opinion was in disagreement with the first opinion.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall be effective for services provided on or after the October 1, 1995.

(c) RURAL EMERGENCY ACCESS CARE HOSPITALS.—

(1) RURAL EMERGENCY ACCESS CARE HOSPITALS DESCRIBED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Rural Emergency Access Care Hospital; Rural Emergency Access Care Hospital Services

''(pp)(1) The term 'rural emergency access care hospital' means, for a fiscal year, a facility in a State participating in a demonstration project under section 1820(b) and that meets the criteria described in subparagraphs (A) through (H) of section 1820(b)(3).

''(2) The term 'rural emergency access care hospital services' means the following services provided by a rural emergency access care hospital:

''(A) An appropriate medical screening examination (as described in section 1867(a)).

''(B) Necessary stabilizing examination and treatment services for an emergency medical condition and labor (as described in section 1867(b)).''.

(2) REQUIRING RURAL EMERGENCY ACCESS CARE HOSPITALS TO MEET HOSPITAL ANTI-DUMPING

REQUIREMENTS.—Section 1867(e)(5) of such Act (42 U.S.C. 1395(e)(5)) is amended by striking ''1861(mm)(1)'' and inserting ''1861(mm)(1)) and a rural emergency access care hospital (as defined in section 1861(pp)(1))''.

(3) COVERAGE OF AND PAYMENT FOR SERVICES.—Section 1832(a)(2) of the Social Security Act (42 U.S.C. 1395k(a)(2)), as amended in subsection (b)(2)(A)(ii), is amended—

(A) by striking ''and'' at the end of subparagraph (J);

(B) by striking the period at the end of subparagraph (K) and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(L) rural emergency access care hospital services (as defined in section 1861(pp)(2)).''

(4) PAYMENT BASED ON PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—

(A) IN GENERAL.—Section 1833(a)(6) of the Social Security Act (42 U.S.C. 1395l(a)(6)) is amended by striking ''services,'' and inserting ''services and rural emergency access care hospital services,''.

(B) PAYMENT METHODOLOGY DESCRIBED.—Section 1834(g) of such Act (42 U.S.C. 1395m(g)) is amended—

(i) in the heading, by striking ''SERVICES'' and inserting ''SERVICES AND RURAL EMERGENCY ACCESS CARE HOSPITAL SERVICES''; and

(ii) by adding at the end the following new paragraph:

''(3) APPLICATION OF METHODS TO PAYMENT FOR RURAL EMERGENCY ACCESS CARE HOSPITAL SERVICES.—The amount of payment for rural emergency access care hospital services provided during a year shall be determined using the applicable method provided under this subsection for determining payment for outpatient rural primary care hospital services during the year.''.

(5) EFFECTIVE DATE.—The amendments made by this subsection shall be effective for services provided on or after the October 1, 1995.

SEC. 353. MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS.

(a) CLARIFICATION OF ADDITIONAL PAYMENT.—Section 1886(d)(5)(G)(ii)(I) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)(ii)(I)) is amended by striking

''the first 3 12-month cost reporting periods that begin'' and inserting ''the 36-month period beginning with the first day of the cost reporting period that begins''.

(b) SPECIAL TREATMENT EXTENDED.—Section 1886(d)(5)(G) of such Act (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(1) in clause (i), by striking ''October 1, 1994'' and inserting ''October 1, 1999''; and

(2) in clause (ii)(II), by striking ''October 1, 1994'' and inserting ''October 1, 1999''.

(c) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) of such Act (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(1) in the matter preceding clause (i), by striking ''March 31, 1993'' and inserting ''September 30, 1999''; and

(2) by amending clause (iii) to read as follows:

''(iii) with respect to discharges occurring in fiscal years 1994 through 1999, the target amount for the cost reporting period beginning in the previous fiscal year increased by the applicable percentage increase under subparagraph (B)(iv).''.

SEC. 354. EXPANDED COVERAGE FOR PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS.

(a) COVERAGE IN OUTPATIENT SETTINGS.—(1) Section 1861(s)(2)(K) of the Social Security Act (42 U.S.C. 1395x(s)(2)(K)) is amended—

(A) in clause (i)—

(i) by striking ''or'' at the end of subclause (II); and

(ii) by inserting ''or (IV) in an outpatient setting as defined by the Secretary'' following ''shortage area,''; and

(B) in clause (ii), by striking ''in a skilled nursing facility or nursing facility (as defined in section 1919(a)'' and inserting ''(I) in a skilled nursing facility or nursing facility (as defined in section 1919(a)), or (II) in an outpatient setting as defined by the Secretary''.

(2) Section 1833(r)(1) of such Act (42 U.S.C. 1395l(r)(1)) is amended by striking ''rural area)'' and inserting ''rural area), or for services described in section 1861(s)(2)(K)(ii)(II) (relating to nurse practitioner services in an outpatient settings)''.

(3) Section 1842(b)(6)(C) (42 U.S.C. 1395u(b)(6)(C)) is amended by striking ''(ii)'' and inserting ''(ii)(II)''.

(b) PAYMENT BASED ON PHYSICIAN FEE SCHEDULE.—

(1) Section 1833(a)(1)(O) of such Act (42 U.S.C. 1395l(a)(1)(O)) is amended—

(A) by striking ''section 1861(s)(2)(K)(iii) (relating to nurse practitioner and clinical nurse specialist services provided in a rural area)'' and inserting ''section 1861(s)(2)(K)'';

(B) by striking ''for services furnished on or after January 1, 1992,'' and inserting ''for services described in section 1861(s)(2)(K)(iii) furnished on or after January 1, 1992, and for services described in clauses (i), (ii), and (iv) of section 1861(s)(2)(K) furnished on or after January 1, 1997,''; and

(C) by striking ''subsection (r)(2)'' and inserting ''subsection (r)(2) or subparagraph (A) or (B) of section 1842(b)(12)''.

(2) Section 1842(b)(12)(A) of such Act (42 U.S.C. 1395u(b)(12)(A)) is amended—

(A) by striking ''and'' at the end of clause (i);

(B) in clause (ii) in the matter preceding subclause (I), by striking ''the prevailing'' and

inserting ''for services furnished before January 1, 1997, the prevailing'';

(C) by striking the period at the end of clause (ii)(II) and inserting ''; and''; and

(D) by inserting at the end the following clause:

''(iii) in the case of services furnished on or after January 1, 1997, the fee schedule amount shall be equal to—

''(I) in the case of services performed as an assistant at surgery, 65 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistance at surgery,

''(II) in the case of services performed (other than as an assistant at surgery) in a hospital, 75 percent of the fee schedule amount specified under section 1848, and

''(III) in the case of other services, 85 percent of the fee schedule amount specified under section 1848.

(c) RURAL NURSE PRACTITIONERS AS ASSISTANTS AT SURGERY IN URBAN AREAS.—Section

1861(s)(2)(K)(ii) of such Act (42 U.S.C. 1395x(s)(2)(K)(ii)), as amended by subsection (a)(2), is further amended by adding ''or services as an assistant at surgery furnished by a nurse practitioner whose primary practice location (as defined by the Secretary) is in a rural area (as defined in section 1886(d)(2)(D)) to an individual who resides in a rural area when the service is furnished to such individual in an urban area by such practitioner when such practitioner refers such individual to an urban area for the furnishing of services'' after ''as defined by the Secretary''.

(d) CONFORMING AMENDMENTS.—

(1) Section 1861(b)(4) of such Act (42 U.S.C. 1395x(b)(4)) is amended by striking ''subsection (s)(2)(K)(i)'' and inserting ''subsection (s)(2)(K)''.

(2) Section 1862(a)(14) of such Act (42 U.S.C. 1395y(a)(14)), as amended by section 620(b)(4)(K), is amended by striking ''section 1861(s)(2)(K)(i)'' and inserting ''section 1861(s)(2)(K)''.

(3) Section 1866(a)(1)(H) of such Act (42 U.S.C. 1395cc(a)(1)(H)), is amended by striking ''section 1861(s)(2)(K)(i)'' and inserting ''section 1861(s)(2)(K)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1997.

Subtitle F—Emergency Medical Systems

SEC. 361. GRANTS TO STATES REGARDING AIRCRAFT FOR TRANSPORTING RURAL VICTIMS OF MEDICAL EMERGENCIES.

Part E of title XII of the Public Health Service Act (42 U.S.C. 300d–51 et seq.) is amended by adding at the end thereof the following new section:

"SEC. 1252. GRANTS FOR SYSTEMS TO TRANSPORT RURAL VICTIMS OF MEDICAL EMERGENCIES.

''(a) IN GENERAL.—The Secretary shall make grants to States to assist such States in the creation or enhancement of air medical transport systems that provide victims of medical emergencies in rural areas with access to treatments for the injuries or other conditions resulting from such emergencies.

''(b) APPLICATION AND PLAN.—

''(1) APPLICATION.—To be eligible to receive a grant under subsection (a), a State shall prepare and submit to the Secretary an application in such form, made in such manner, and containing such agreements, assurances, and information, including

a State plan as required in paragraph (2), as the Secretary determines to be necessary to carry out this section.

''(2) STATE PLAN.—An application submitted under paragraph (1) shall contain a State plan that shall—

''(A) describe the intended uses of the grant proceeds and the geographic areas to be served;

''(B) demonstrate that the geographic areas to be served, as described under subparagraph (A), are rural in nature;

''(C) demonstrate that there is a lack of facilities available and equipped to deliver advanced levels of medical care in the geographic areas to be served;

''(D) demonstrate that in utilizing the grant proceeds for the establishment or enhancement of air medical services the State would be making a cost-effective improvement to existing ground-based or air emergency medical service systems;

''(E) demonstrate that the State will not utilize the grant proceeds to duplicate the capabilities of existing air medical systems that are

effectively meeting the emergency medical needs of the populations they serve;

''(F) demonstrate that in utilizing the grant proceeds the State is likely to achieve a reduction in the morbidity and mortality rates of the areas to be served, as determined by the Secretary;

''(G) demonstrate that the State, in utilizing the grant proceeds, will—

''(i) maintain the expenditures of the State for air and ground medical transport systems at a level equal to not less than the level of such expenditures maintained by the State for the fiscal year preceding the fiscal year for which the grant is received; and

''(ii) ensure that recipients of direct financial assistance from the State under such grant will maintain expenditures of such recipients for such systems at a level at least equal to the level of such expenditures maintained by such recipients for the fiscal year preceding the fiscal year for which the financial assistance is received;

''(H) demonstrate that persons experienced in the field of air medical service delivery were consulted in the preparation of the State plan; and

''(I) contain such other information as the Secretary may determine appropriate.

''(c) CONSIDERATIONS IN AWARDING GRANTS.—In determining whether to award a grant to a State under this section, the Secretary shall—

''(1) consider the rural nature of the areas to be served with the grant proceeds and the services to be provided with such proceeds, as identified in the State plan submitted under subsection (b); and

''(2) give preference to States with State plans that demonstrate an effective integration of the proposed air medical transport systems into a comprehensive network or plan for regional or statewide emergency medical service delivery.

''(d) STATE ADMINISTRATION AND USE OF GRANT.—

''(1) IN GENERAL.—The Secretary may not make a grant to a State under subsection (a) unless the State agrees that such grant will be administered by the State agency with principal responsibility for carrying out programs regarding the provi-

sion of medical services to victims of medical emergencies or trauma.

''(2) PERMITTED USES.—A State may use amounts received under a grant awarded under this section to award subgrants to public and private entities operating within the State.

''(3) OPPORTUNITY FOR PUBLIC COMMENT.—The Secretary may not make a grant to a State under subsection (a) unless that State agrees that, in developing and carrying out the State plan under subsection (b)(2), the State will provide public notice with respect to the plan (including any revisions thereto) and facilitate comments from interested persons.

''(e) NUMBER OF GRANTS.—The Secretary shall award grants under this section to not less than 7 States.

''(f) REPORTS.—

''(1) REQUIREMENT.—A State that receives a grant under this section shall annually (during each year in which the grant proceeds are used) prepare and submit to the Secretary a report that shall contain—

''(A) a description of the manner in which the grant proceeds were utilized;

''(B) a description of the effectiveness of the air medical transport programs assisted with grant proceeds; and

''(C) such other information as the Secretary may require.

''(2) TERMINATION OF FUNDINGS.—In reviewing reports submitted under paragraph (1), if the Secretary determines that a State is not using amounts provided under a grant awarded under this section in accordance with the State plan submitted by the State under subsection (b), the Secretary may terminate the payment of amounts under such grant to the State until such time as the Secretary determines that the State comes into compliance with such plan.

''(g) DEFINITION.—As used in this section, the term 'rural areas' means geographic areas that are located outside of standard metropolitan statistical areas, as identified by the Secretary.

''(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to make grants under this section, $15,000,000 for fiscal year 1995, and such sums as may be necessary for each for fiscal years 1996 and 1997.''.

Subtitle G—Studies and Reports

SEC. 371. ASSISTANT SECRETARY FOR RURAL HEALTH.

(a) APPOINTMENT OF ASSISTANT SECRETARY.—

(1) IN GENERAL.—Section 711(a) of the Social Security Act (42 U.S.C. 912(a)) is amended—

(A) by striking ''by a Director, who shall advise the Secretary'' and inserting ''by an Assistant Secretary for Rural Health (in this section referred to as the 'Assistant Secretary'), who shall report directly to the Secretary''; and

(B) by adding at the end the following new sentence: ''The Office shall not be a component of any other office, service, or component of the Department.''.

(2) CONFORMING AMENDMENTS.—(A) Section 711(b) of the Social Security Act (42 U.S.C. 912(b)) is amended by striking ''the Director'' and inserting ''the Assistant Secretary''.

(B) Section 338J(a) of the Public Health Service Act (42 U.S.C. 254r(a)) is amended by striking ''Director of the Office of Rural Health Policy'' and inserting ''Assistant Secretary for Rural Health''.

(C) Section 464T(b) of the Public Health Service Act (42 U.S.C. 285p–2(b)) is amended in the matter preceding paragraph (1) by striking ''Direc-

tor of the Office of Rural Health Policy'' and inserting ''Assistant Secretary for Rural Health''.

(D) Section 6213 of the Omnibus Budget Reconciliation Act of 1989 (42 U.S.C. 1395x note) is amended in subsection (e)(1) by striking ''Director of the Office of Rural Health Policy'' and inserting ''Assistant Secretary for Rural Health''.

(E) Section 403 of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (42 U.S.C. 300ff–11 note) is amended in the matter preceding paragraph (1) of subsection (a) by striking ''Director of the Office of Rural Health Policy'' and inserting ''Assistant Secretary for Rural Health''.

(3) AMENDMENT TO THE EXECUTIVE SCHEDULE.—Section 5315 of title 5, United States Code, is amended by striking ''Assistant Secretaries of Health and Human Services (5)'' and inserting ''Assistant Secretaries of Health and Human Services (6)''.

(b) EXPANSION OF DUTIES.—Section 711(a) of the Social Security Act (42 U.S.C. 912(a)) is amended by striking ''and access to (and the quality of) health care in rural areas'' and inserting ''access to, and quality of, health care in rural areas, and reforms to the health care

system and the implications of such reforms for rural areas''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1996.

SEC. 372. STUDY ON TRANSITIONAL MEASURES TO ENSURE ACCESS.

(a) IN GENERAL.—The Prospective Payment Assessment Commission shall conduct a study concerning the need for legislation or regulations to ensure that vulnerable populations have adequate access to health plans and health care providers and services.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Prospective Payment Assessment Commission shall prepare and submit to Congress a report concerning the findings and recommendations of the Commission based on the study conducted under subsection (a).

SEC. 373. STUDY ON EXPANDING BENEFITS UNDER HEALTH PLANS FOR INDIVIDUALS RESIDING IN RURAL AREAS.

(a) STUDY.—

(1) IN GENERAL.—The Secretary shall conduct a study on the possible benefits of a program under which issuers of health plans covering individuals who reside in rural areas may—

(A) develop a package of benefits targeted at improving access to health care services which would supplement the benefits included under such plan; and

(B) receive premium payments for such package of benefits from the Secretary under the Medicare or Medicaid programs.

(2) CONSULTATION WITH CERTAIN ENTITIES.—In conducting the study under paragraph (1), the Secretary shall consult with the Office of Rural Health Policy and private and public entities with expertise in rural health issues.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act the Secretary shall submit a report to Congress containing the results of the study conducted under subsection (a) and any legislative recommendations determined appropriate by the Secretary.

TITLE IV—LONG-TERM CARE PROVISIONS

SEC. 400. AMENDMENT OF INTERNAL REVENUE CODE OF 1986.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a

section or other provision of the Internal Revenue Code of 1986.

Subtitle A—Long-Term Care Services and Contracts

PART I—GENERAL PROVISIONS

SEC. 401. QUALIFIED LONG-TERM CARE SERVICES TREATED AS MEDICAL CARE.

(a) GENERAL RULE.—Paragraph (1) of section 213(d) (defining medical care) is amended by striking ''or'' at the end of subparagraph (B), by redesignating subparagraph (C) as subparagraph (D), and by inserting after subparagraph (B) the following new subparagraph:

''(C) for qualified long-term care services (as defined in subsection (g)), or''.

(b) QUALIFIED LONG-TERM CARE SERVICES DEFINED.—Section 213 (relating to deduction for medical, dental, etc. expenses), as amended by section 101, is amended by adding at the end the following new subsection:

''(g) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified long-term care services' means necessary diagnostic, preventive, therapeutic, rehabilitative, and maintenance (including personal care) services—

''(A) which are required by an individual during any period during which such individual is a functionally impaired individual,

''(B) which have as their primary purpose the provision of needed assistance with 1 or more activities of daily living which a functionally impaired individual is certified as being unable to perform under paragraph (2)(A), and

''(C) which are provided pursuant to a continuing plan of care prescribed by a licensed health care practitioner (other than a relative of such individual).

''(2) FUNCTIONALLY IMPAIRED INDIVIDUAL.—

''(A) IN GENERAL.—The term 'functionally impaired individual' means any individual who is certified by a licensed health care practitioner (other than a relative of such individual) as being unable to perform, without substantial assistance from another individual (including assistance involving verbal reminding, physical cueing, or substantial supervision), at least 3 activities of daily living described in paragraph (3).

''(B) SPECIAL RULE FOR HOME HEALTH CARE SERVICES.—In the case of services which

are provided during any period during which an individual is residing within the individual's home (whether or not the services are provided within the home), subparagraph (A) shall be applied by substituting '2' for '3'. For purposes of this subparagraph, a nursing home or similar facility shall not be treated as a home.

''(3) ACTIVITIES OF DAILY LIVING.—Each of the following is an activity of daily living:

''(A) Eating.

''(B) Transferring.

''(C) Toileting.

''(D) Dressing.

''(E) Bathing.

''(4) LICENSED HEALTH CARE PRACTITIONER.—

''(A) IN GENERAL.—The term 'licensed health care practitioner' means—

''(i) a physician or registered professional nurse,

''(ii) a qualified community care case manager (as defined in subparagraph (B)), or

''(iii) any other individual who meets such requirements as may be prescribed by

the Secretary after consultation with the Secretary of Health and Human Services.

''(B) QUALIFIED COMMUNITY CARE CASE MANAGER.—The term 'qualified community care case manager' means an individual or entity which—

''(i) has experience or has been trained in providing case management services and in preparing individual care plans;

''(ii) has experience in assessing individuals to determine their functional and cognitive impairment;

''(iii) is not a relative of the individual receiving case management services; and

''(iv) meets such requirements as may be prescribed by the Secretary after consultation with the Secretary of Health and Human Services.

''(5) RELATIVE.—The term 'relative' means an individual bearing a relationship to another individual which is described in paragraphs (1) through (8) of section 152(a).''

(c) TECHNICAL AMENDMENTS.—

(1) Subparagraph (D) of section 213(d)(1) (as redesignated by subsection (a)) is amended to read as follows:

''(D) for insurance (including amounts paid as premiums under part B of title XVIII of the Social Security Act, relating to supplementary medical insurance for the aged)—

''(i) covering medical care referred to in subparagraphs (A) and (B), or

''(ii) covering medical care referred to in subparagraph (C), but only if such coverage is provided under a qualified long-term care insurance contract (as defined in section 7702B(b)).''

(2) Paragraph (6) of section 213(d) is amended—

(A) by striking ''subparagraphs (A) and (B)'' in the matter preceding subparagraph (A) and inserting ''subparagraphs (A), (B), and (C)'', and

(B) by striking ''paragraph (1)(C)'' in subparagraph (A) and inserting ''paragraph (1)(D)''.

(3) Paragraph (7) of section 213(d) is amended by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)''.

SEC. 402. TREATMENT OF LONG-TERM CARE INSURANCE OR PLANS.

(a) GENERAL RULE.—Chapter 79 (relating to definitions) is amended by inserting after section 7702A the following new section:

''SEC. 7702B. TREATMENT OF LONG-TERM CARE INSURANCE OR PLANS.

''(a) GENERAL RULE.—For purposes of this title—

''(1) a qualified long-term care insurance contract shall be treated as an accident or health insurance contract,

''(2) any plan of an employer providing coverage of qualified long-term care services shall be treated as an accident or health plan with respect to such services,

''(3) amounts received under such a contract or plan with respect to qualified long-term care services shall be treated as amounts received for personal injuries or sickness, and

''(4) payments described in subsection (b)(5) shall be treated as payments made with respect to qualified long-term care services.

''(b) QUALIFIED LONG-TERM CARE INSURANCE CONTRACT.—

''(1) IN GENERAL.—For purposes of this title, the term 'qualified long-term care insurance contract' means any insurance contract if—

''(A) the only insurance protection provided under such contract is coverage of qualified long-term care services,

''(B) such contract meets the requirements of paragraphs (2), (3), and (4), and

''(C) such contract is issued by a qualified issuer.

''(2) PREMIUM REQUIREMENTS.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to a contract if such contract provides that—

''(i) premium payments may not be made earlier than the date such payments would have been made if the contract provided for level annual payments over the life of the contract (or, if shorter, 20 years), and

''(ii) all refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a

reduction in future premiums or to increase future benefits.

A contract shall not be treated as failing to meet the requirements of clause (i) solely by reason of a provision providing for a waiver of premiums if the policyholder becomes a functionally impaired individual.

''(B) REFUNDS UPON DEATH OR COMPLETE SURRENDER OR CANCELLATION.—Subparagraph (A)(ii) shall not apply to any refund on the death of the policyholder, or on any complete surrender or cancellation of the contract, if, under the contract, the amount refunded may not exceed the amount of the premiums paid under the contract. For purposes of this title, any refund described in the preceding sentence shall be includible in gross income to the extent that any deduction or exclusion was allowed with respect to the refund.

''(3) BORROWING, PLEDGING, OR ASSIGNING PROHIBITED.—The requirements of this paragraph are met with respect to a contract if such contract provides that no money may be borrowed under such contract and that such contract (or any portion

thereof) may not be assigned or pledged as collateral for a loan.

''(4) PROHIBITION OF DUPLICATE PAYMENT.—The requirements of this paragraph are met with respect to a contract if such contract does not cover expenses incurred to the extent that such expenses are reimbursable under title XVIII of the Social Security Act.

''(5) PER DIEM AND OTHER PERIODIC PAYMENTS PERMITTED.—

''(A) IN GENERAL.—For purposes of subsection (a)(4), and except as provided in subparagraph (B), payments are described in this paragraph for any calendar year if, under the contract, such payments are made to (or on behalf of) a functionally impaired individual on a per diem or other periodic basis without regard to the expenses incurred or services rendered during the period to which the payments relate.

''(B) EXCEPTION WHERE AGGREGATE PAYMENTS EXCEED LIMIT.—If the aggregate payments under the contract for any period (whether on a periodic basis or otherwise) exceed the dollar amount in effect for such period—

''(i) subparagraph (A) shall not apply for such period, and

''(ii) the requirements of paragraph (1)(A) shall be met only if such payments are made with respect to qualified long-term care services provided during such period.

''(C) DOLLAR AMOUNT.—The dollar amount in effect under this paragraph shall be $150 per day (or the equivalent amount in the case of payments on another periodic basis).

''(D) ADJUSTMENTS FOR INCREASED COSTS.—

''(i) IN GENERAL.—In the case of any calendar year after 1995, the dollar amount in effect under subparagraph (C) for any period occurring during such calendar year shall be equal to the sum of—

''(I) the amount in effect under subparagraph (C) for the preceding calendar year (after application of this subparagraph), plus

''(II) the applicable percentage of the amount under subclause (I).

''(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the term 'applicable percentage' means, with respect to any calendar year, the greater of—

''(I) 5 percent, or

''(II) the cost-of-living adjustment for such calendar year.

''(iii) COST-OF-LIVING ADJUSTMENT.—For purposes of clause (ii), the cost-of-living adjustment for any calendar year is the percentage (if any) by which the cost index under clause (iv) for the preceding calendar year exceeds such index for the second preceding calendar year. In the case of any calendar year beginning before 1997, this clause shall be applied by substituting the Consumer Price Index (as defined in section 1(f)(5)) for the cost index under clause (iv).

''(iv) COST INDEX.—The Secretary, in consultation with the Secretary of Health and Human Services, shall before January 1, 1997, establish a cost index to measure increases in costs of nursing home and similar facilities. The Secretary may from

time to time revise such index to the extent necessary to accurately measure increases or decreases in such costs.

''(E) AGGREGATION RULE.—For purposes of this paragraph, all contracts issued with respect to the same policyholder by the same company shall be treated as 1 contract.

''(c) QUALIFIED ISSUER.—For purposes of this section, the term 'qualified issuer' means any person which at the time of the issuance of a long-term care insurance contract—

''(1) uses a one year preliminary term method for setting up reserves, and

''(2) maintains a capital ratio equal to not less than 25 percent of long-term care insurance premium receivables.

''(d) SPECIAL RULES FOR TAX TREATMENT OF POLICYHOLDERS.—For purposes of this title, solely with respect to the policyholder under any qualified long-term care insurance contract—

''(1) AGGREGATE PAYMENTS IN EXCESS OF LIMITS.—If the aggregate payments under all qualified long-term care insurance contracts with respect to an policyholder for any period (whether on a peri-

odic basis or otherwise) exceed the dollar amount in effect for such period under subsection (b)(5)—

''(A) subsection (b)(5) shall not apply for such period, and

''(B) such payments shall be treated as made for qualified long-term care services only if made with respect to such services provided during such period.

''(2) ASSIGNMENT OR PLEDGE.—Such contract shall not be treated as a qualified long-term care insurance contract during any period on or after the date on which the contract (or any portion thereof) is assigned or pledged as collateral for a loan.

''(e) TREATMENT OF COVERAGE AS PART OF A LIFE INSURANCE CONTRACT.—Except as provided in regulations, in the case of coverage of qualified long-term care services provided as part of a life insurance contract, the requirements of this section shall apply as if the portion of the contract providing such coverage was a separate contract.

''(f) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified long-term care services' has the meaning given such term by section 213(g).

''(2) RECERTIFICATION.—If an individual has been certified as a functionally impaired individual under section 213(g)(2)(A), services shall not be treated as qualified long-term care services with respect to the individual unless such individual is recertified no less frequently than annually as a functionally impaired individual in the same manner as under such section, except that such recertification may be made by any licensed health care practitioner (as defined in section 213(g)(4)), other than a relative (as defined by section 213(g)(5)) of such individual.

''(g) CONTINUATION COVERAGE EXCISE TAX NOT TO APPLY.—Section 4980B shall not apply to—

''(1) qualified long-term care insurance contracts, or

''(2) plans described in subsection (a)(2).

''(h) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the requirements of this section, including regulations to prevent the avoidance of this section by providing qualified long-term care services under a life insurance contract.''

(b) CAFETERIA PLANS.—Section 125(f) is amended by adding at the end the following new sentence: ''Such term does not include any coverage or benefits under a

qualified long-term care insurance contract (as defined in section 7702B).''

(c) RESERVES.—Clause (iii) of section 807(d)(3)(A) is amended by inserting ''(other than a qualified long-term care insurance contract within the meaning of section 7702B)'' after ''contract''.

(d) CLERICAL AMENDMENT.—The table of sections for chapter 79 is amended by inserting after the item relating to section 7702A the following new item:

''Sec. 7702B. Treatment of long-term care insurance or plans.''

SEC. 403. EFFECTIVE DATES.

(a) SECTION 401.—The amendments made by section 401 shall apply to taxable years beginning after December 31, 1994.

(b) SECTION 402.—The amendments made by section 402 shall apply to contracts issued after December 31, 1994.

(c) TRANSITION RULE.—If, after the date of the enactment of this Act and before January 1, 1995, a contract providing coverage for services which are similar to qualified long-term care services (as defined in section 213(g) of the Internal Revenue Code of 1986) and issued on or before January 1, 1994, is exchanged for a qualified long-term care insurance contract (as defined in section 7702B(b) of such Code), such exchange shall be treated

as an exchange to which section 1035 of such Code applies.

PART II—CONSUMER PROTECTION PROVISIONS

SEC. 406. POLICY REQUIREMENTS.

(a) IN GENERAL.—Section 7702B (as added by section 402) is amended by redesignating subsection (h) as subsection (i) and by inserting after subsection (g) the following new subsection:

''(h) CONSUMER PROTECTION PROVISIONS.—

''(1) IN GENERAL.—The requirements of this subsection are met with respect to any contract if any long-term care insurance policy issued under the contract meets—

''(A) the requirements of the model regulation and model Act described in paragraph (2),

''(B) the disclosure requirement of paragraph (3),

''(C) the requirements relating to nonforfeitability under paragraph (4), and

''(D) the requirements relating to rate stabilization under paragraph (5).

''(2) REQUIREMENTS OF MODEL REGULATION AND ACT.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to any policy if such policy meets—

''(i) MODEL REGULATION.—The following requirements of the model regulation:

''(I) Section 7A (relating to guaranteed renewal or noncancellability), and the requirements of section 6B of the model Act relating to such section 7A.

''(II) Section 7B (relating to prohibitions on limitations and exclusions).

''(III) Section 7C (relating to extension of benefits).

''(IV) Section 7D (relating to continuation or conversion of coverage).

''(V) Section 7E (relating to discontinuance and replacement of policies).

''(VI) Section 8 (relating to unintentional lapse).

''(VII) Section 9 (relating to disclosure), other than section 9F thereof.

''(VIII) Section 10 (relating to prohibitions against post-claims underwriting).

''(IX) Section 11 (relating to minimum standards).

''(X) Section 12 (relating to requirement to offer inflation protection), except that any requirement for a signature on a rejection of inflation protection shall permit the signature to be on an application or on a separate form.

''(XI) Section 23 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

''(ii) MODEL ACT.—The following requirements of the model Act:

''(I) Section 6C (relating to preexisting conditions).

''(II) Section 6D (relating to prior hospitalization).

''(B) DEFINITIONS.—For purposes of this paragraph—

''(i) MODEL PROVISIONS.—The terms 'model regulation' and 'model Act' mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted in January of 1993).

''(ii) COORDINATION.—Any provision of the model regulation or model Act listed under clause (i) or (ii) of subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision.

''(3) TAX DISCLOSURE REQUIREMENT.—The requirement of this paragraph is met with respect to any policy if such policy meets the requirements of section 4980C(d)(1).

''(4) NONFORFEITURE REQUIREMENTS.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to any level premium long-term care insurance policy, if the issuer of such policy offers to the policyholder,

including any group policyholder, a nonforfeiture provision meeting the requirements of subparagraph (B).

''(B) REQUIREMENTS OF PROVISION.—The nonforfeiture provision required under subparagraph (A) shall meet the following requirements:

''(i) The nonforfeiture provision shall be appropriately captioned.

''(ii) The nonforfeiture provision shall provide for a benefit available in the event of a default in the payment of any premiums and the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying policies approved by the Secretary for the same policy form.

''(iii) The nonforfeiture provision shall provide at least one of the following:

''(I) Reduced paid-up insurance.

''(II) Extended term insurance.

''(III) Shortened benefit period.

''(IV) Other similar offerings approved by the Secretary.

''(5) RATE STABILIZATION.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to any long-term care insurance policy, including any group master policy, if—

''(i) such policy contains the minimum rate guarantees specified in subparagraph (B), and

''(ii) the issuer of such policy meets the requirements specified in subparagraph (C).

''(B) MINIMUM RATE GUARANTEES.—The minimum rate guarantees specified in this subparagraph are as follows:

''(i) Rates under the policy shall be guaranteed for a period of at least 3 years from the date of issue of the policy.

''(ii) After the expiration of the 3-year period required under clause (i), any rate increase shall be guaranteed for a period of at least 2 years from the effective date of such rate increase.

''(iii) In the case of any individual age 75 or older who has maintained coverage under a long-term care insurance policy for 10 years, rate increases under such policy shall not exceed 10 percent in any 12-month period.

''(C) INCREASES IN PREMIUMS.—The requirements specified in this subparagraph are as follows:

''(i) IN GENERAL.—If an issuer of any long-term care insurance policy, including any group master policy, plans to increase the premium rates for a policy, such issuer shall, at least 90 days before the effective date of the rate increase, offer to each individual policyholder under such policy the option to remain insured under the policy at a reduced level of benefits which maintains the premium rate at the rate in effect on the day before the effective date of the rate increase.

''(ii) INCREASES OF MORE THAN 50 PERCENT.—

''(I) IN GENERAL.—If an issuer of any long-term care insurance pol-

icy, including any group master policy, increases premium rates for a policy by more than 50 percent in any 3-year period—

''(aa) in the case of a group master long-term care insurance policy, the issuer shall discontinue issuing all group master long-term care insurance policies in any State in which the issuer issues such policy for a period of 2 years from the effective date of such premium increase; and

''(bb) in the case of an individual long-term care insurance policy, the issuer shall discontinue issuing all individual long-term care policies in any State in which the issuer issues such policy for a period of 2 years from the effective date of such premium increase.

''(II) APPLICABILITY.—Subclause (I) shall apply to any issuer of long-term care insurance policies or any

other person that purchases or otherwise acquires any long-term care insurance policies from another issuer or person.

''(D) MODIFICATIONS OR WAIVERS OF REQUIREMENTS.—The Secretary may modify or waive any of the requirements under this paragraph if—

''(i) such requirements will adversely affect an issuer's solvency;

''(ii) such modification or waiver is required for the issuer to meet other State or Federal requirements;

''(iii) medical developments, new disabling diseases, changes in long-term care delivery, or a new method of financing long-term care will result in changes to mortality and morbidity patterns or assumptions;

''(iv) judicial interpretation of a policy's benefit features results in unintended claim liabilities; or

''(v) in the case of a purchase or other acquisition of long-term care insurance policies of an issuer or other person, the

continued sale of other long-term care insurance policies by the purchasing issuer or person is in the best interests of individual consumers.

''(6) LONG-TERM CARE INSURANCE POLICY DEFINED.—For purposes of this subsection, the term 'long-term care insurance policy' has the meaning given such term by section 4980C(e).''

(b) CONFORMING AMENDMENT.—Section 7702B(b)(1)(B) (as added by section 402) is amended by inserting ''and of subsection (h)'' after ''and (4)''.

SEC. 407. ADDITIONAL REQUIREMENTS FOR ISSUERS OF LONG-TERM CARE INSURANCE POLICIES.

(a) IN GENERAL.—Chapter 43 is amended by adding at the end the following new section:

''SEC. 4980C. FAILURE TO MEET REQUIREMENTS FOR LONG-TERM CARE INSURANCE POLICIES.

''(a) GENERAL RULE.—There is hereby imposed on any person failing to meet the requirements of subsection (c) or (d) a tax in the amount determined under subsection (b).

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—The amount of the tax imposed by subsection (a) shall be $100 per policy for each day any requirements of subsection (c), (d), or

(e) are not met with respect to each long-term care insurance policy.

''(2) WAIVER.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that payment of the tax would be excessive relative to the failure involved.

''(c) ADDITIONAL RESPONSIBILITIES.—The requirements of this subsection are as follows:

''(1) REQUIREMENTS OF MODEL PROVISIONS.—

''(A) MODEL REGULATION.—The following requirements of the model regulation must be met:

''(i) Section 13 (relating to application forms and replacement coverage).

''(ii) Section 14 (relating to reporting requirements), except that the issuer shall also report at least annually the number of claims denied during the reporting period for each class of business (expressed as a percentage of claims denied), other than claims denied for failure to meet the waiting period or because of any applicable pre-existing condition.

''(iii) Section 20 (relating to filing requirements for marketing).

''(iv) Section 21 (relating to standards for marketing), including inaccurate completion of medical histories, other than sections 21C(1) and 21C(6) thereof, except that—

''(I) in addition to such requirements, no person shall, in selling or offering to sell a long-term care insurance policy, misrepresent a material fact; and

''(II) no such requirements shall include a requirement to inquire or identify whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance.

''(v) Section 22 (relating to appropriateness of recommended purchase).

''(vi) Section 24 (relating to standard format outline of coverage).

''(vii) Section 25 (relating to requirement to deliver shopper's guide).

''(B) MODEL ACT.—The following requirements of the model Act must be met:

''(i) Section 6F (relating to right to return), except that such section shall also apply to denials of applications and any refund shall be made within 30 days of the return or denial.

''(ii) Section 6G (relating to outline of coverage).

''(iii) Section 6H (relating to requirements for certificates under group plans).

''(iv) Section 6I (relating to policy summary).

''(v) Section 6J (relating to monthly reports on accelerated death benefits).

''(vi) Section 7 (relating to incontestability period).

''(C) DEFINITIONS.—For purposes of this paragraph, the terms 'model regulation' and 'model Act' have the meanings given such terms by section 7702B(h)(2)(B).

''(2) DELIVERY OF POLICY.—If an application for a long-term care insurance policy (or for a certificate under a group long-term care insurance policy) is approved, the issuer shall deliver to the appli-

cant (or policyholder or certificate-holder) the policy (or certificate) of insurance not later than 30 days after the date of the approval.

''(3) INFORMATION ON DENIALS OF CLAIMS.—If a claim under a long-term care insurance policy is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificate-holder (or representative)—

''(A) provide a written explanation of the reasons for the denial, and

''(B) make available all information directly relating to such denial.

''(d) DISCLOSURE.—The requirements of this subsection are met if either of the following statements, whichever is applicable, is prominently displayed on the front page of any long-term care insurance policy and in the outline of coverage required under subsection (c)(1)(B)(ii):

''(1) A statement that: 'This policy is intended to be a qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986.'.

''(2) A statement that: 'This policy is not intended to be a qualified long-term care insurance

contract under section 7702B(b) of the Internal Revenue Code of 1986.'.

''(e) LONG-TERM CARE INSURANCE POLICY DEFINED.—For purposes of this section, the term 'long-term care insurance policy' means any product which is advertised, marketed, or offered as long-term care insurance.''

(b) CONFORMING AMENDMENT.—The table of sections for chapter 43 is amended by adding at the end the following new item:

''Sec. 4980C. Failure to meet requirements for long-term care insurance policies.''

SEC. 408. COORDINATION WITH STATE REQUIREMENTS.

Nothing in this part shall be construed as preventing a State from applying standards that provide greater protection of policyholders of long-term care insurance policies (as defined in section 4980C(e) of the Internal Revenue Code of 1986).

SEC. 409. UNIFORM LANGUAGE AND DEFINITIONS.

(a) IN GENERAL.—The National Association of Insurance Commissioners shall not later than January 1, 1996, promulgate standards for the use of uniform language and definitions in long-term care insurance policies (as defined in section 4980C(e) of the Internal Revenue Code 1986).

(b) VARIATIONS.—Standards under subsection (a) may permit the use of nonuniform language to the extent

required to take into account differences among States in the licensing of nursing facilities and other providers of long-term care.

SEC. 410. EFFECTIVE DATES.

(a) IN GENERAL.—The provisions of, and amendments made by, this part shall apply to contracts issued after December 31, 1994. The provisions of section 403(c) of this Act shall apply to such contracts.

(b) ISSUERS.—The amendments made by section 407 shall apply to actions taken after December 31, 1994.

Subtitle B—Tax Treatment of Accelerated Death Benefits

SEC. 411. TAX TREATMENT OF ACCELERATED DEATH BENEFITS UNDER LIFE INSURANCE CONTRACTS.

(a) GENERAL RULE.—Section 101 (relating to certain death benefits) is amended by adding at the end the following new subsection:

''(g) TREATMENT OF CERTAIN ACCELERATED DEATH BENEFITS.—

''(1) IN GENERAL.—For purposes of this section, any amount received under a life insurance contract on the life of an insured who is a terminally ill individual shall be treated as an amount paid by reason of the death of such insured.

''(2) NECESSARY CONDITIONS.—

''(A) IN GENERAL.—Paragraph (1) shall not apply to any amount received unless—

''(i) the total amount received is not less than the present value (determined under subparagraph (B)) of the reduction in the death benefit otherwise payable in the event of the death of the insured, and

''(ii) the percentage reduction in the cash surrender value of the contract by reason of the distribution does not exceed the percentage reduction in the death benefit payable under the contract by reason of such distribution.

''(B) PRESENT VALUE.—The present value of the reduction in the death benefit shall be determined by—

''(i) using a discount rate which is based on an interest rate which does not exceed the highest interest rate set forth in subparagraph (C), and

''(ii) assuming that the death benefit (or the portion thereof) would have been paid on the date which is 12 months after the date of the certification referred to in paragraph (3).

''(C) RATES.—The interest rates set forth in this subparagraph are the following:

''(i) the 90-day Treasury bill yield,

''(ii) the rate described as Moody's Corporate Bond Yield Average-Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto, for the calendar month ending 2 months before the date on which the rate is determined, and

''(iii) the rate used to compute the cash surrender values under the contract during the applicable period plus 1 percent per annum.

''(D) SPECIAL RULES RELATING TO LIENS.—If a lien is imposed against a life insurance contract with respect to any amount referred to in paragraph (1)—

''(i) for purposes of subparagraph (A), the amount of such lien shall be treated as a reduction (at the time of receipt) in the death benefit or cash surrender value to the extent that such benefit or value, as the case may be, is (or may become) subject to the lien, and

''(ii) paragraph (1) shall not apply to the amount received unless any rate of interest with respect to any amount in connection with which such lien is imposed does not exceed the highest rate set forth in subparagraph (C).

''(3) TERMINALLY ILL INDIVIDUAL.—For purposes of this subsection, the term 'terminally ill individual' means an individual who the insurer has determined, after receipt of an acceptable certification by a licensed physician, has an illness or physical condition which can reasonably be expected to result in death within 12 months after the date of certification.

''(4) EXCEPTION FOR BUSINESS-RELATED POLICIES.—This subsection shall not apply in the case of any amount paid to any taxpayer other than the insured if such taxpayer has an insurable interest with respect to the life of the insured by reason of the insured being a director, officer, or employee of the taxpayer or by reason of the insured having a financial interest in any trade or business carried on by the taxpayer.''

(b) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by this section shall apply to amounts received after the date of the enactment of this Act.

(2) DELAY IN APPLICATION OF DISCOUNT RULES.—Clause (i) of section 101(g)(2)(A) of the Internal Revenue Code of 1986 shall not apply to any amount received before January 1, 1995.

(3) ISSUANCE OF RIDER NOT TREATED AS MATERIAL CHANGE.—For purposes of applying section 101(f), 7702, or 7702A of the Internal Revenue Code of 1986 to any contract, the issuance of a qualified accelerated death benefit rider (as defined in section 818(g) of such Code (as added by this Act)) shall not be treated as a modification or material change of such contract.

SEC. 412. TAX TREATMENT OF COMPANIES ISSUING QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.

(a) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—Section 818 (relating to other definitions and special rules) is amended by adding at the end the following new subsection:

''(g) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—For purposes of this part—

''(1) IN GENERAL.—Any reference to a life insurance contract shall be treated as including a reference to a qualified accelerated death benefit rider on such contract.

''(2) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.—For purposes of this subsection, the term 'qualified accelerated death benefit rider' means any rider on a life insurance contract which provides for a distribution to an individual upon the insured becoming a terminally ill individual (as defined in section 101(g)(3)).''

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1995.

Subtitle C—Credit for Personal Assistance

SEC. 421. CREDIT FOR COST OF PERSONAL ASSISTANCE SERVICES REQUIRED BY EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 (relating to nonrefundable personal credits) is amended by inserting after section 23 the following new section:

"SEC. 24. COST OF PERSONAL ASSISTANCE SERVICES REQUIRED BY EMPLOYED INDIVIDUALS.

''(a) ALLOWANCE OF CREDIT.—

''(1) IN GENERAL.—In the case of an eligible individual, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the applicable percentage of the personal assistance expenses paid or incurred by the taxpayer during such taxable year.

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the term 'applicable percentage' means 50 percent reduced (but not below zero) by 10 percentage points for each $5,000 by which the modified adjusted gross income (as defined in section 59B(d)(2)) of the taxpayer for the taxable year exceeds $45,000. In the case of a married individual filing a separate return, the preceding sentence shall be applied by substituting '$2,500' for '$5,000' and '$22,500' for '$45,000'.

''(b) LIMITATION.—The amount of personal assistance expenses for the benefit of an individual which may be taken into account under subsection (a) for the taxable year shall not exceed the lesser of—

''(1) $15,000, or

''(2) such individual's earned income (as defined in section 32(c)(2)) for the taxable year.

In the case of a joint return, the amount under the preceding sentence shall be determined separately for each spouse.

''(c) ELIGIBLE INDIVIDUAL.—For purposes of this section, the term 'eligible individual' means any individual (other than a nonresident alien) who, by reason of any medically determinable physical impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, is unable to engage in any substantial gainful employment activity without personal assistance services appropriate to carry out activities of daily living. An individual shall not be treated as an eligible individual unless such individual furnishes such proof thereof (in such form and manner, and at such times) as the Secretary may require.

''(d) OTHER DEFINITIONS.—For purposes of this section—

''(1) PERSONAL ASSISTANCE EXPENSES.—The term 'personal assistance expenses' means expenses for—

''(A) personal assistance services appropriate to carry out activities of daily living in or outside the home,

''(B) homemaker/chore services incidental to the provision of such personal assistance services,

''(C) communication services,

''(D) work-related support services,

''(E) coordination of services described in this paragraph,

''(F) technology and devices necessary to assist an individual in carrying out the activities of daily living or gainful employment activities, including assessment of the need for particular technology and devices and training of family members, and

''(G) modifications to the principal place of abode of the individual to the extent the expenses for such modifications would (but for subsection (e)(2)) be expenses for medical care (as defined by section 213) of such individual.

''(2) ACTIVITIES OF DAILY LIVING.—The term 'activities of daily living' means eating, toileting, transferring, bathing, and dressing.

''(e) SPECIAL RULES.—

''(1) PAYMENTS TO RELATED PERSONS.—No credit shall be allowed under this section for any amount paid by the taxpayer to any person who is

related (within the meaning of section 267 or 707(b)) to the taxpayer.

''(2) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—Any amount taken into account in determining the credit under this section shall not be taken into account in determining the amount of the deduction under section 213.

''(3) BASIS REDUCTION.—For purposes of this subtitle, if a credit is allowed under this section for any expense with respect to any property, the increase in the basis of such property which would (but for this paragraph) result from such expense shall be reduced by the amount of the credit so allowed.

''(f) COST-OF-LIVING ADJUSTMENT.—In the case of any taxable year beginning after 1996, the $45,000 and $22,500 amounts in subsection (a)(2) and the $15,000 amount in subsection (b) shall be increased by an amount equal to—

''(1) such dollar amount, multiplied by

''(2) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins by substituting 'calendar year 1995' for 'calendar year 1992' in subparagraph (B) thereof.

If any increase determined under the preceding sentence is not a multiple of $1,000, such increase shall be rounded to the nearest multiple of $1,000.''

(b) TECHNICAL AMENDMENT.—Subsection (a) of section 1016 is amended by striking ''and'' at the end of paragraph (24), by striking the period at the end of paragraph (25) and inserting '', and'', and by adding at the end thereof the following new paragraph:

''(26) in the case of any property with respect to which a credit has been allowed under section 24, to the extent provided in section 24(e)(3).''

(c) CLERICAL AMENDMENT.—The table of sections for subpart A of part IV of subchapter A of chapter 1 is amended by inserting after the item relating to section 23 the following new item:

''Sec. 24. Cost of personal assistance services required by employed individuals.''

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

TITLE V—HEALTH CARE PROVIDERS

Subtitle A—Education and Research

SEC. 501. ADVISORY COMMISSION ON WORKFORCE.

(a) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

''(j) ADVISORY COMMISSION ON WORK FORCE.—

''(1) ESTABLISHMENT.—The Director of the Congressional Office of Technology Assessment (in this subsection referred to as the 'Director' and the 'Office', respectively) shall provide for the appointment of an Advisory Commission on Workforce (in this subsection referred to as the 'Advisory Commission') without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

''(2) MEMBERSHIP.—

''(A) COMPOSITION.—The Commission shall consist of 17 individuals with expertise in medical education, the operation of teaching hospitals, the operation of health plans, and other interested individuals.

''(B) TERMS.—Members of the Commission shall first be appointed by no later than October 1, 1995, for a term of 3 years, except that the Director may provide initially for such shorter terms as will ensure that (on a continuing basis) the terms of no more than 4 members expire in any 1 year.

''(C) CHAIR AND VICE CHAIR.—The Commission shall select a Chair and Vice Chair from among its members.

''(3) MEETINGS.—

''(A) IN GENERAL.—The Commission shall meet at the call of the Chair.

''(B) INITIAL MEETING.—No later than 30 days after the date on which all members of the Commission have been appointed, the Commission shall hold its first meeting.

''(C) QUORUM.—A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

''(4) DUTIES OF THE COMMISSION.—

''(A) IN GENERAL.—The Commission shall not later than October 1, 1996, submit to the Committee on Finance and the Committee on

Labor and Human Resources of the Senate and the Committee on Ways and Means, the Committee on Education and Labor, and the Committee on Energy and Commerce of the House of Representatives a report on national health care workforce policy and payment that includes—

''(i) assessments and recommendations, as appropriate, in the following areas:

''(I) The composition of the physician and non-physician national health care workforce and how such composition addresses the needs of the health care market.

''(II) Sources and uses of funds related to graduate medical education and options for future payment policy.

(III) Current payment distribution methods related to graduate medical education and options for future distribution policy.

''(IV) Current incentives to encourage health care practitioners to enter primary health care specialty

areas and to provide services in underserved areas and options for future policies.

''(V) Current role, composition, distribution, and costs related to foreign medical graduates in the national health care workforce and options for future policies;

''(ii) recommendations for a coordinated policy for the future direction and distribution of grants, demonstration projects, and other funding affecting the health care workforce; and

(iii) recommendations and a schedule for topics to be addressed in subsequent quarterly reports, based on the findings and recommendations of the Commission described in the previous clauses.

''(5) CONSULTATION.—The Commission shall develop its recommendations and assessments under this subsection in consultation with the Physician Payment Review Commission, the Prospective Payment Assessment Commission, and private expert entities as appropriate.

''(6) CERTAIN PROVISIONS APPLICABLE.—Section 1845(c)(1) shall apply to the Commission in the same manner as it applies to the Physician Payment Review Commission.

''(7) AUTHORIZATION OF APPROPRIATIONS.—In addition to any amounts made available by the amendment made by subsection (b) of section 501 of the America's Health Care Option Act, there are authorized to be appropriated such sums as may be necessary to carry out the provisions of this subsection.''.

(b) CONFORMING AMENDMENT REPEALING THE COUNCIL ON GRADUATE MEDICAL EDUCATION.—Effective October 1, 1995, section 30 of the Health Professions Extension Amendments of 1992 (Public Law 102-408) is repealed.

SEC. 502. GRADUATE MEDICAL EDUCATION CONSORTIUM DEMONSTRATION PROJECTS.

(a) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 501, is amended by adding at the end the following new subsection:

''(k) CONSORTIUM DEMONSTRATION PROGRAM.—

''(1) IN GENERAL.—The Secretary, in consultation with the Advisory Commission on Workforce

(established under subsection (j)), shall provide for the establishment of demonstration projects for no more than 10 health care training consortia which are located in a State or are multi-State consortia for the purpose of testing and evaluating mechanisms to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice through the use of funds otherwise available for direct graduate medical education costs under subsection (h).

''(2) APPLICATIONS.—

''(A) IN GENERAL.—Each health care training consortium desiring to conduct a demonstration project under this subsection shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including an explanation of a plan for evaluating the project.

''(B) APPROVAL OF APPLICATIONS.—A consortium that submits an application under subparagraph (A) may begin a demonstration project under this subsection—

''(i) upon approval of such application by the Secretary; or

''(ii) at the end of the 60-day period beginning on the date such application is submitted, unless the Secretary denies the application during such period.

''(3) FUNDING FOR DEMONSTRATION PROJECTS.—

''(A) ALLOCATION OF GME FUNDS.—

''(i) IN GENERAL.—For each year a consortium conducts a demonstration project under this subsection the Secretary shall pay to such consortium an amount equal to the total amount available to hospitals that are members of the consortium under subsection (h). The consortium shall designate a teaching hospital for each resident assigned to the consortium which the Secretary shall use to calculate the consortium's payment amount under such section. Such teaching hospital shall be the hospital where the resident receives the majority of the resident's hospital-based, nonambulatory training experience.

''(ii) ADDITIONAL INCENTIVE PAYMENT.—For each year a consortium conducts a demonstration project under this subsection the Secretary shall also pay to selected consortium an amount equal to an incentive amount according to a formula to be determined by the Secretary that would allocate the amount made available pursuant to subsection (d)(5)(B)(v) in such year among the consortia conducting a demonstration project under this subsection.

''(iii) USE OF FUNDS.—

''(I) TESTING AND EVALUATION.—Each consortium that receives a payment under clause (i) shall use such funds to conduct activities which test and evaluate mechanisms to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice.

''(II) ESTABLISHMENT AND OPERATION.—Each consortium that receives a payment under clause (i) may also use such funds for the establish-

ment and operation of the consortium. The Secretary shall make payments to the consortium through an entity identified by the consortium as appropriate for receiving payment on behalf of the consortium. The consortium shall have discretion in determining the purposes for which such payments may be used.

''(B) GRANTS FOR PLANNING AND EVALUATIONS.—

''(i) IN GENERAL.—The Secretary may award grants to consortia conducting demonstration projects under this subsection for the purpose of developing and evaluating such projects. Each consortium desiring to receive a grant under this subparagraph shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

''(ii) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to

carry out the purposes of this subparagraph for fiscal years 1995 through 2003.

''(4) MAINTENANCE OF EFFORT.—Any funds available for the activities covered by a demonstration project conducted under this subsection shall supplement, and shall not supplant, funds that are expended for similar purposes under any State, regional, or local program.

''(5) DURATION.—A demonstration project under this subsection shall be conducted for a period not to exceed 8 years. The Secretary may terminate a project if the Secretary determines that the consortium conducting the project is not in substantial compliance with the terms of the application approved by the Secretary under this subsection.

''(6) EVALUATIONS AND REPORTS.—

''(A) EVALUATIONS.—Each consortium that conducts a demonstration project under this subsection shall submit to the Secretary and the Advisory Commission on Workforce a final evaluation of such project within 360 days of the termination of such project and such interim evaluations as the Secretary may require.

''(B) REPORTS TO CONGRESS.—Not later than 360 days after the first demonstration

project under this subsection begins, and annually thereafter for each year in which a project is conducted under this subsection, the Secretary shall submit a report to the appropriate committees of the Congress which evaluates the effectiveness of the demonstration projects conducted under this subsection and includes any legislative recommendations determined appropriate by the Secretary.

''(7) DEFINITIONS.—For purposes of this subsection:

''(A) AMBULATORY TRAINING SITES.—The term 'ambulatory training sites' includes, but is not limited to, health maintenance organizations, federally qualified health centers, community health centers, migrant health centers, rural health clinics, nursing homes, hospice, and other community-based providers, including private practices.

''(B) HEALTH CARE TRAINING CONSORTIUM.—The term 'health care training consortium' includes a State, regional, or local entity which—

''(i) includes, but is not limited to partnerships of teaching hospitals, ambula-

tory training sites, and one or more schools of medicine; and

''(ii) is operated in a manner intended to ensure that by the end of the 8-year demonstration project there will be an increase in the number and percentage of medical school students entering primary care practice relative to those entering nonprimary care practice.

''(C) PRIMARY CARE.—The term 'primary care' means family practice, general internal medicine, and general pediatrics, and obstetrics and gynecology.''.

(b) SOURCE OF INCENTIVE PAYMENTS.—Section 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following new clause:

''(v) For the purpose of making payments pursuant to subsection (k)(3)(A)(ii) for fiscal years 1996, 1997, 1998, 1999, and 2000, there shall be available from the Federal Hospital Insurance Trust Fund $200,000,000 of the amount that would have been expended under this subparagraph if the amendments made by section 816 of the America's Health Care Option Act had not been in effect.''.

SEC. 503. FUNDING UNDER MEDICARE FOR TRAINING IN NONHOSPITAL-OWNED FACILITIES.

(a) RESIDENCY TRAINING TIME IN NONHOSPITAL-OWNED FACILITIES COUNTED IN DETERMINING FULL-TIME-EQUIVALENT RESIDENTS FOR DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.—Section 1886(h)(4)(E) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(E)) is amended by striking ‘‘, if the hospital incurs all, or substantially all, of the costs for the training program in that setting’’.

(b) RESIDENCY TRAINING TIME IN NONHOSPITAL-OWNED FACILITIES COUNTED IN DETERMINING FULL-TIME-EQUIVALENT RESIDENTS FOR INDIRECT MEDICAL EDUCATION PAYMENTS.—

(1) IN GENERAL.—Section 1886(d)(5)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amended to read as follows:

‘‘(iv) In determining such adjustment, the Secretary shall—

‘‘(I) count interns and residents assigned to any patient service environment which is part of the hospital’s approved medical residency training program (as defined in subsection (h)(5)(A)); and

''(II) count interns and residents providing services at any entity receiving a grant under section 330 of the Public Health Service Act that is under the ownership or control of a hospital (if the hospital incurs all, or substantially all, of the costs of the services furnished by such interns and residents),

as part of the calculation of the full-time-equivalent number of interns and residents.''.

(2) ADJUSTMENT OF INDIRECT TEACHING ADJUSTMENT FACTOR TO ACHIEVE BUDGET NEUTRALITY.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following new clause:

''(vi) The Secretary shall reduce all payments under this subparagraph by such percentage as the Secretary determines necessary so that, beginning on the date of the enactment of the America's Health Care Option Act, the amendments made by section 503(b)(1) of such Act would not result in expenditures under this subparagraph that exceed the

amount of such expenditures that would have been made if such amendments had not been made.''.

SEC. 504. NATIONAL FUND FOR MEDICAL RESEARCH.

(a) DESIGNATION OF OVERPAYMENTS AND CONTRIBUTIONS FOR THE NATIONAL FUND FOR MEDICAL RESEARCH.—

(1) IN GENERAL.—Subchapter A of chapter 61 of the Internal Revenue Code of 1986 (relating to returns and records) is amended by adding at the end the following new part:

''PART IX—DESIGNATION OF OVERPAYMENTS AND CONTRIBUTIONS FOR THE NATIONAL FUND FOR MEDICAL RESEARCH

''Sec. 6097. Amounts for the National Fund for Medical Research.

''SEC. 6097. AMOUNTS FOR THE NATIONAL FUND FOR MEDICAL RESEARCH.

''(a) IN GENERAL.—Every individual (other than a nonresident alien) may designate that—

''(1) a portion (not less than $1) of any overpayment of the tax imposed by chapter 1 for the taxable year, and

''(2) a cash contribution (not less than $1),

be paid over to the National Fund for Medical Research. In the case of a joint return of a husband and wife, each

spouse may designate one-half of any such overpayment of tax (not less than $2).

''(b) MANNER AND TIME OF DESIGNATION.—Any designation under subsection (a) may be made with respect to any taxable year only at the time of filing the original return of the tax imposed by chapter 1 for such taxable year. Such designation shall be made either on the 1st page of the return or on the page bearing the taxpayer's signature.

''(c) OVERPAYMENTS TREATED AS REFUNDED.—For purposes of this section, any overpayment of tax designated under subsection (a) shall be treated as being refunded to the taxpayer as of the last day prescribed for filing the return of tax imposed by chapter 1 (determined with regard to extensions) or, if later, the date the return is filed.

''(d) DESIGNATED AMOUNTS NOT DEDUCTIBLE.—No deduction shall be allowed under subtitle A with respect to any amount designated pursuant to subsection (a) for any taxable year.

''(e) TERMINATION.—This section shall not apply to taxable years beginning in a calendar year after a determination by the Secretary that the sum of all designations under subsection (a) for taxable years beginning in the

second and third calendar years preceding the calendar year is less than $5,000,000.''.

(2) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 61 of such Code is amended by adding at the end the following new item:

''Part IX. Designation of overpayments and contributions for the National Fund for Medical Research.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 1994.

(b) ESTABLISHMENT OF THE NATIONAL FUND FOR MEDICAL RESEARCH.—

(1) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to the trust fund code) is amended by adding at the end the following new section:

''SEC. 9512. NATIONAL FUND FOR MEDICAL RESEARCH.

''(a) CREATION OF FUND.—There is established in the Treasury of the United States a fund to be known as the ''National Fund for Medical Research'', consisting of such amounts as may be credited or paid to such Fund as provided in this section or section 9602(b).

''(b) TRANSFERS TO FUND.—There is hereby transferred to the National Fund for Medical Research amounts equivalent to the amounts designated under sec-

tion 6097 (relating to designation of overpayments and contributions to the Fund).

''(c) EXPENDITURES FROM FUND.—

''(1) IN GENERAL.—The Secretary shall pay annually, within 30 days after the President signs an appropriations Act for the Departments of labor, Health and Human Services, and Education, and related agencies, or by the end of the first quarter of the fiscal year, to the Secretary of Health and Human Services on behalf of the National Institutes of Health, an amount equal to the amount in the National Fund for Medical Research at the time of such payment, to carry out the purposes of section 404F of the Public Health Service Act, less any administrative expenses which may be paid under paragraph (2).

''(2) ADMINISTRATIVE EXPENSES.—Amounts in the National Fund for Medical Research shall be available to pay the administrative expenses of the Department of the Treasury directly allocable to—

''(A) modifying the individual income tax return forms to carry out section 6097,

''(B) carrying out this chapter with respect to such Fund, and

''(C) processing amounts received under section 6097 and transferring such amounts to such Fund.

''(d) BUDGET TREATMENT OF AMOUNTS IN FUND.—The amounts in the National Fund for Medical Research shall be excluded from, and shall not be taken into account, for purposes of any budget enforcement procedure under the Congressional Budget Act of 1974 or the Balanced Budget and Emergency Deficit Control Act of 1985.''.

(2) CLERICAL AMENDMENT.—The table of sections for subchapter A of chapter 98 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''Sec. 9512. National Fund for Medical Research.''.

(c) PURPOSES FOR EXPENDITURES FROM FUND.—Part A of title IV of the Public Health Service Act is amended by adding at the end the following new section:

''SEC. 404F. EXPENDITURES FROM THE NATIONAL FUND FOR MEDICAL RESEARCH.

''(a) DISTRIBUTION OF AMOUNTS.—From amounts received for any fiscal year from the National Fund for Medical Research, the Secretary shall distribute—

''(1) 3 percent of such amounts to the Director of NIH to be allocated at the Director's discretion for—

''(A) carrying out the responsibilities of the Director of NIH, including the Office of Research on Women's Health, the Office of Research on Minority Health, the Office on Alternative Medicine, and the Office of Rare Disease Research;

''(B) construction of, and acquisition of equipment for, facilities of or used by the National Institutes of Health; and

''(C) transfer to the National Center for Research Resources to carry out section 481A concerning biomedical and behavioral research facilities;

''(2) 1 percent of such amounts for carrying out section 301 and part D of this title with respect to health information communications; and

''(3) the remainder of such amounts to member institutes and centers of the National Institutes of Health in the same proportion to the total amount received under this subsection, as the amount of annual appropriations under appropriations Acts for each member institute or center for the fiscal year bears to the total amount of appropriations under appropriations Acts for all member institutes and

centers of the National Institutes of Health for the fiscal year.

''(b) PLANS OF ALLOCATION.—The amounts transferred under subsection (a) shall be allocated by the Director of NIH or the various directors of the institutes and centers, as the case may be, pursuant to allocation plans developed by the various advisory councils to such directors, after consultation with such directors.

''(c) GRANTS AND CONTRACTS FULLY FUNDED IN FIRST YEAR.—With respect to any grant or contract funded by amounts distributed under subsection (a), the full amount of the total obligation of such grant or contract shall be funded in the first year of such grant or contract, and shall remain available until expended.

''(d) MAINTENANCE OF EFFORT.—No amounts transferred under subsection (a) shall replace or reduce the amount of appropriations for the National Institutes of Health under appropriations Acts.''.

Subtitle B—Health Care Liability Reform

SEC. 511. HEALTH CARE LIABILITY REFORM.

(a) IN GENERAL.—Part A of subtitle A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128B the following new section:

"SEC. 1129. HEALTH CARE LIABILITY REFORM.

''(a) DEFINITIONS.—As used in this section:

''(1) CLAIMANT.—The term 'claimant' means any person who commences a health care liability action, and any person on whose behalf such an action is commenced, including the decedent in the case of an action brought through or on behalf of an estate.

''(2) CLEAR AND CONVINCING EVIDENCE.—The term 'clear and convincing evidence' is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established, except that such measure or degree of proof is more than that required under preponderance of the evidence, but less than that required for proof beyond a reasonable doubt.

''(3) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action in a State or Federal court—

''(A) against a health care provider, health care professional, or other defendant joined in the action (regardless of the theory of liability on which the action is based) in which the claimant alleges injury related to the provision of, or the failure to provide, health care services; or

''(B) against a health care payor, a health maintenance organization, insurance company, or any other individual, organization, or entity that provides payment for health care benefits in which the claimant alleges that injury was caused by the payment for, or the failure to make payment for, health care benefits, except to the extent such actions are subject to the Employee Retirement Income Security Act of 1974.

''(3) HEALTH CARE PROFESSIONAL.—The term 'health care professional' means any individual who provides health care services in a State and who is required by Federal or State laws or regulations to be licensed, registered or certified to provide such services or who is certified to provide health care services pursuant to a program of education, training and examination by an accredited institution, professional board, or professional organization.

''(4) HEALTH CARE PROVIDER.—The term 'health care provider' means any organization or institution that is engaged in the delivery of health care services in a State and that is required by Federal or State laws or regulations to be licensed, reg-

istered or certified to engage in the delivery of such services.

''(5) HEALTH CARE SERVICES.—The term 'health care services' means any services provided by a health care professional or health care provider, or any individual working under the supervision of a health care professional, that relate to the diagnosis, prevention, or treatment of any disease or impairment, or the assessment of the health of human beings.

''(6) INJURY.—The term 'injury' means any illness, disease, or other harm that is the subject of a health care liability action.

''(7) NONECONOMIC LOSSES.—The term 'noneconomic losses' means losses for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of consortium, and other nonpecuniary losses incurred by an individual with respect to which a health care liability action is brought.

''(8) PUNITIVE DAMAGES.—The term 'punitive damages' means damages awarded, for the purpose of punishment or deterrence, and not for compensatory purposes, against a health care provider,

health care organization, or other defendant in a health care liability action. Punitive damages are neither economic nor noneconomic damages.

''(b) APPLICABILITY.—

''(1) IN GENERAL.—Except as provided in paragraph (3), this section shall apply with respect to any health care liability action brought in any Federal or State court, except that this section shall not apply to an action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the action.

''(2) PREEMPTION.—The provisions of this section shall preempt any State law to the extent such law is inconsistent with the limitations contained in such provisions. The provisions of this section shall not preempt any State law that—

''(A) provides for defenses in addition to those contained in this section, places greater limitations on the amount of attorneys' fees that can be collected, or otherwise imposes greater restrictions on non-economic or punitive damages than those provided in this section;

''(B) permits State officials to commence health care liability actions as a representative of an individual; or

''(C) permits provider-based dispute resolution.

''(3) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in this section shall be construed to—

''(A) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

''(B) waive or affect any defense of sovereign immunity asserted by the United States;

''(C) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

''(D) preempt State choice-of-law rules with respect to actions brought by a foreign nation or a citizen of a foreign nation; or

''(E) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss an action of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

''(4) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this section shall be construed to establish any jurisdiction in the district courts of the United States over health care liability actions on the basis of sections 1331 or 1337 of title 28, United States Code.

''(c) STATUTE OF LIMITATIONS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), no health care liability action may be initiated after the expiration of the 2-year period that begins on the date on which the alleged injury and its cause should reasonably have been discovered, but in no event later than 5 years after the date of the alleged occurrence of the injury.

''(2) EXCEPTION FOR MINORS.—In the case of an alleged injury suffered by a minor who has not attained 6 years of age, no health care liability action may be initiated after the expiration of the 2-year period that begins on the date on which the alleged injury and its cause should reasonably have been discovered, but in no event later than 6 years after the date of the alleged occurrence of the injury and its cause or the date on which the minor attains 11 years of age, whichever is later.

''(d) REFORM OF NONECONOMIC DAMAGES.—

''(1) IN GENERAL.—With respect to a health care liability action brought in any forum, the total amount of damages that may be awarded to an individual and the family members of such individual for noneconomic losses resulting from an injury alleged under such action may not exceed $250,000, regardless of the number of health care professionals, health care providers, and other defendants against whom the action is brought or the number of actions brought with respect to the injury. If the jury's damage award exceeds such limitation, a reduction in such award shall be made by the court.

''(2) STUDY.—The Secretary, in consultation with the Attorney General, shall conduct a study to determine an appropriate schedule with respect to an increase in the limitation described in paragraph (1) in years subsequent to the calendar year in which this section is enacted. Not later than January 1, 1997, the Secretary shall submit such a schedule to Congress.

''(3) JOINT RESOLUTION AND CONSIDERATION BY CONGRESS.—

''(A) IN GENERAL.—The schedule under paragraph (2) shall be implemented unless a

joint resolution (described in subparagraph (B)) disapproving such recommendations is enacted in accordance with the provisions of subparagraph (C), before the end of the 45-day period beginning on the date on which such schedule was submitted. For purposes of applying the preceding sentence and subparagraphs (B) and (C), the days on which either House of Congress is not in session because of an adjournment of more than three days to a day certain shall be excluded in the computation of a period.

''(B) JOINT RESOLUTION OF DISAPPROVAL.—A joint resolution described in this subparagraph means only a joint resolution which is introduced within the 10-day period beginning on the date on which the Secretary submits the schedule under paragraph (2) and—

''(i) which does not have a preamble;

''(ii) the matter after the resolving clause of which is as follows: ''That Congress disapproves the schedule of the Secretary of Health and Human Services concerning adjustments in limitations on non-

economic damages with respect to health care liability actions, as submitted by the Secretary on _____.'', the blank space being filled in with the appropriate date; and

''(iii) the title of which is as follows: ''Joint resolution disapproving the schedule of the Secretary of Health and Human Services concerning adjustments in limitations on noneconomic damages with respect to health care liability actions, as submitted by the Secretary on _____.'', the blank space being filled in with the appropriate date.

''(C) PROCEDURES FOR CONSIDERATION OF RESOLUTION OF DISAPPROVAL.—Subject to subparagraph (D), the provisions of section 2908 (other than subsection (a)) of the Defense Base Closure and Realignment Act of 1990 shall apply to the consideration of a joint resolution described in subparagraph (B) in the same manner as such provisions apply to a joint resolution described in section 2908(a) of such Act.

''(D) SPECIAL RULES.—For purposes of applying subparagraph (C) with respect to such provisions—

''(i) any reference to the Committee on Armed Services of the House of Representatives shall be deemed a reference to an appropriate Committee of the House of Representatives (specified by the Speaker of the House of Representatives at the time of submission of recommendations under paragraph (1)) and any reference to the Committee on Armed Services of the Senate shall be deemed a reference to an appropriate Committee of the Senate (specified by the Majority Leader of the Senate at the time of submission of recommendations under paragraph (1)); and

''(ii) any reference to the date on which the President transmits a report shall be deemed a reference to the date on which the Secretary submits a recommendation under paragraph (1).

''(e) REFORM OF PUNITIVE DAMAGES.—

''(1) LIMITATION.—With respect to a health care liability action, an award for punitive damages

may only be made, if otherwise permitted by applicable law, if it is proven by clear and convincing evidence—

''(A) that the defendant intended to injure the claimant for a reason unrelated to the provision of health care services;

''(B) that the defendant understood the claimant was substantially certain to suffer unnecessary injury, yet the defendant in providing or failing to provide health care services, deliberately failed to avoid such injury; or

''(C) that the defendant acted with a conscious disregard of a substantial and unjustifiable risk of unnecessary injury which the defendant failed to avoid in a manner which constitutes a gross deviation from the normal standard of conduct in such circumstances.

''(2) PUNITIVE DAMAGES NOT PERMITTED.—Notwithstanding the provisions of paragraph (1), punitive damages may not be awarded against a defendant with respect to any health care liability action if—

''(A) no judgment for compensatory damages, including nominal damages (under $500), is rendered against the defendant; or

''(B) the underlying health care liability action arises out of the same act or course of conduct by the defendant that resulted in a prior award of punitive damages to any individual.

''(3) REQUIREMENTS FOR PLEADING OF PUNITIVE DAMAGES.—

''(A) IN GENERAL.—The claimant's complaint or initial pleading in any health care liability action may not include a demand for punitive damages.

''(B) AMENDED PLEADING.—A court may allow a claimant to file an amended complaint or pleading for punitive damages if—

''(i) the claimant submits a motion to amend the complaint or pleading within the earlier of—

''(I) 2 years after the complaint or initial pleading is filed, or

''(II) 9 months before the date the matter is first set for trial; and

''(ii) after a finding by a court upon review of supporting and opposing affidavits or after a hearing, that after weighing the evidence the claimant has established

by a substantial probability that the claimant will prevail on the claim for punitive damages.

''(4) SEPARATE PROCEEDING.—

''(A) IN GENERAL.—At the request of any defendant in a health care liability action, the trier of fact shall consider in a separate proceeding—

''(i) whether punitive damages are to be awarded and the amount of such award, or

''(ii) the amount of punitive damages following a determination of punitive liability.

''(B) ONLY RELEVANT EVIDENCE ADMISSIBLE.—If a defendant requests a separate proceeding under subparagraph (A), evidence relevant only to the claim of punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

''(5) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

''(A) IN GENERAL.—In determining the amount of punitive damages, the trier of fact shall consider only the following:

''(i) The severity of the harm caused by the conduct of the defendant.

''(ii) The duration of the conduct or any concealment of it by the defendant.

''(iii) The profitability of the conduct of the defendant.

''(iv) The number of products sold or medical procedures rendered for compensation, as the case may be, by the defendant of the kind causing the harm complained of by the claimant.

''(v) Awards of punitive or exemplary damages to persons similarly situated to the claimant, when offered by the defendant.

''(vi) Prospective awards of compensatory damages to persons similarly situated to the claimant.

''(vii) Any criminal penalties imposed on the defendant as a result of the conduct complained of by the claimant, when offered by the defendant.

''(viii) The amount of any civil fines assessed against the defendant as a result of the conduct complained of by the claimant, when offered by the defendant.

''(B) LIMITATION ON AMOUNT OF PUNITIVE DAMAGES.—In no event shall the amount of punitive damages awarded exceed the lesser of 2 times the amount of compensatory damages awarded or $500,000. The jury shall not be informed of this limitation.

''(6) RESTRICTIONS PERMITTED.—Nothing in this section shall be construed to imply a right to seek punitive damages where none exists under Federal or State law.

''(7) HEALTH CARE QUALITY ASSURANCE PROGRAM.—

''(A) FUND.—Each participating State shall establish a health care quality assurance program, to be approved by the Secretary, and a fund consisting of such amounts as are transferred to the fund under subparagraph (B).

''(B) TRANSFER OF AMOUNTS.—Each participating State shall require that 50 percent of all awards of punitive damages resulting from all health care liability actions in that State be

transferred to the fund established under subparagraph (B) in the State.

''(C) OBLIGATIONS FROM FUND.—The chief executive officer of a participating State shall obligate such sums as are available in the fund established in that State under subparagraph (A) to—

''(A) license and certify health care professionals in the State;

''(B) implement health care quality assurance programs; and

''(C) carry out programs to reduce malpractice-related costs for health care providers volunteering to provide health care services in medically underserved areas.

''(f) PERIODIC PAYMENTS.—With respect to a health care liability action, no person may be required to pay more than $100,000 for future damages in a single payment of a damages award, but a person shall be permitted to make such payments of the award on a periodic basis. The periods for such payments shall be determined by the adjudicating body, based upon projections of future losses and shall be reduced to present value. The adjudicating body may waive the requirements of this subsection if such

body determines that such a waiver is in the interests of justice.

''(g) SCOPE OF LIABILITY.—

''(1) IN GENERAL.—With respect to punitive and noneconomic damages, the liability of each defendant in a health care liability action shall be several only and may not be joint. Such a defendant shall be liable only for the amount of punitive or noneconomic damages allocated to the defendant in direct proportion to such defendant's percentage of fault or responsibility for the injury suffered by the claimant.

''(2) DETERMINATION OF PERCENTAGE OF LIABILITY.—The trier of fact in a health care liability action shall determine the extent of each defendant's fault or responsibility for injury suffered by the claimant, and shall assign a percentage of responsibility for such injury to each such defendant.

''(3) PROHIBITION ON VICARIOUS LIABILITY.—A defendant in a health care liability action may not be held vicariously liable for the direct actions or omissions of other individuals.

''(h) MANDATORY OFFSETS FOR DAMAGES PAID BY A COLLATERAL SOURCE.—

''(1) IN GENERAL.—With respect to a health care liability action, the total amount of damages received by an individual under such action shall be reduced, in accordance with paragraph (2), by any other payment that has been, or will be, made to an individual to compensate such individual for the injury that was the subject of such action.

''(2) AMOUNT OF REDUCTION.—The amount by which an award of damages to an individual for an injury shall be reduced under paragraph (1) shall be—

''(A) the total amount of any payments (other than such award) that have been made or that will be made to such individual to pay costs of or compensate such individual for the injury that was the subject of the action; minus

''(B) the amount paid by such individual (or by the spouse, parent, or legal guardian of such individual) to secure the payments described in subparagraph (A) and any portion of the award subject to a subrogation lien or claim.

''(i) TREATMENT OF ATTORNEYS' FEES AND OTHER COSTS.—

''(1) LIMITATION ON AMOUNT OF CONTINGENCY FEES.—

''(A) IN GENERAL.—An attorney who represents, on a contingency fee basis, a claimant in a health care liability action may not charge, demand, receive, or collect for services rendered in connection with such action in excess of the following amount recovered by judgment or settlement under such action:

''(i) 33⅓ percent of the first $150,000 (or portion thereof) recovered, based on after-tax recovery, plus

''(ii) 25 percent of any amount in excess of $150,000 recovered, based on after-tax recovery.

''(B) CALCULATION OF PERIODIC PAYMENTS.—In the event that a judgment or settlement includes periodic or future payments of damages, the amount recovered for purposes of computing the limitation on the contingency fee under subparagraph (A) shall be based on the cost of the annuity or trust established to make the payments. In any case in which an annuity or trust is not established to make such pay-

ments, such amount shall be based on the present value of the payments.

''(3) CONTINGENCY FEE DEFINED.—As used in this subsection, the term 'contingency fee' means any fee for professional legal services which is, in whole or in part, contingent upon the recovery of any amount of damages, whether through judgment or settlement.

''(j) OBSTETRIC CASES.—With respect to a health care liability action relating to services provided during labor or the delivery of a baby, if the health care professional against whom the action is brought did not previously treat the pregnant woman for the pregnancy, the trier of fact may not find that the defendant committed malpractice and may not assess damages against the health care professional unless the malpractice is proven by clear and convincing evidence.

''(k) REQUIREMENTS FOR RISK MANAGEMENT PROGRAMS.—

''(1) REQUIREMENTS FOR PROVIDERS.—Each State shall require each health care professional and health care provider providing services in the State to participate in a risk management program to prevent and provide early warning of practices which

may result in injuries to patients or which otherwise may endanger patient safety.

''(2) REQUIREMENTS FOR INSURERS.—Each State shall require each entity which provides health care professional or provider liability insurance to health care professionals and health care providers in the State to—

''(A) establish risk management programs based on data available to such entity or sanction programs of risk management for health care professionals and health care providers provided by other entities; and

''(B) require each such professional or provider, as a condition of maintaining insurance, to participate in one program described in subparagraph (A) at least once in each 3-year period.

''(l) PERMITTING STATE PROFESSIONAL SOCIETIES TO PARTICIPATE IN DISCIPLINARY ACTIVITIES.—

''(1) ROLE OF PROFESSIONAL SOCIETIES.—Notwithstanding any other provision of State or Federal law, a State agency responsible for the conduct of disciplinary actions for a type of health care provider may enter into agreements with State or county professional societies of such type of health

care professional to permit such societies to participate in the licensing of such health care professional, and to review any health care liability action, health care liability allegation, or other information concerning the practice patterns of any such health care professional. Any such agreement shall comply with paragraph (2).

''(2) REQUIREMENTS OF AGREEMENTS.—Any agreement entered into under paragraph (1) for licensing activities or the review of any health care liability action, health care liability allegation, or other information concerning the practice patterns of a health care professional shall provide that—

''(A) the health care professional society conducts such activities or review as expeditiously as possible;

''(B) after the completion of such review, such society shall report its findings to the State agency with which it entered into such agreement;

''(C) the conduct of such activities or review and the reporting of such findings be conducted in a manner which assures the preservation of confidentiality of health care information and of the review process; and

''(D) no individual affiliated with such society is liable for any damages or injury directly caused by the individual's actions in conducting such activities or review.

''(3) AGREEMENTS NOT MANDATORY.—Nothing in this subsection may be construed to require a State to enter into agreements with societies described in paragraph (1) to conduct the activities described in such paragraph.

''(4) EFFECT OF AGREEMENT.—

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to health care liability actions arising on or after January 1, 1995.

Subtitle C—Health Care Antitrust Improvements

SEC. 521. PROTECTION FROM ANTITRUST LAWS FOR CERTAIN COMPETITIVE AND COLLABORATIVE ACTIVITIES.

(a) PROTECTIONS DESCRIBED.—An activity relating to the provision of health care services shall receive the following protection from the antitrust laws:

(1) If the activity is within a safe harbor designated by the Attorney General under section 522, the safe harbor shall be a defense to all antitrust claims, except for claims for injunctive relief as-

serted by the Attorney General or the Chair in extraordinary circumstances.

(2) If the activity is specified in and in compliance with the terms of a certificate of review issued by the Attorney General under section 523 and the activity occurs while the certificate is in effect, the certificate shall be a defense to antitrust claims, other than claims for injunctive relief.

(b) AWARD OF ATTORNEY'S FEES AND COSTS OF SUIT.—

(1) IN GENERAL.—If any person brings an action alleging a claim under the antitrust laws and the activity on which the claim is based is found by the court to be protected from such laws under subsection (a), the court shall, at the conclusion of the action—

(A) award to a substantially prevailing claimant the cost of suit attributable to such claim, including a reasonable attorney's fee, or

(B) award to a substantially prevailing party defending against such claim the cost of such suit attributable to such claim, including reasonable attorney's fee, if the claim, or the claimant's conduct during litigation of the

claim, was frivolous, unreasonable, without foundation, or in bad faith.

(2) OFFSET IN CASES OF BAD FAITH.—The court may reduce an award made pursuant to paragraph (1) in whole or in part by an award in favor of another party for any part of the cost of suit (including a reasonable attorney's fee) attributable to conduct during the litigation by any prevailing party that the court finds to be frivolous, unreasonable, without foundation, or in bad faith.

SEC. 522. DESIGNATION OF SAFE HARBORS.

(a) IN GENERAL.—

(1) DESIGNATION BY ATTORNEY GENERAL.—The Attorney General, in consultation with the Secretary and the Chair, shall develop and designate pursuant to paragraph (C) safe harbors for purposes of section 521(a)(1) relating to—

(A) each category of activities referred to in paragraph (2); and

(B) such other categories of activities as the Attorney General may designate in accordance with the process described in this section.

(2) REQUIRED CATEGORIES OF ACTIVITIES SUBJECT TO SAFE HARBORS.—The categories of activities referred to in this paragraph are as follows:

(A) JOINT PURCHASING OF HEALTH CARE SERVICES.—Providing the terms under which consumers of health care services (patients or others acting on their behalf) may jointly negotiate and purchase health care services.

(B) SMALL HOSPITAL MERGERS.—Providing for small hospitals lawfully to merge under the antitrust laws without undue delay or review, taking into account the special needs and circumstances of rural health care markets.

(C) NETWORK FORMATION AND OPERATION.—Permitting activities related to the startup and operation of collaborations between State-licensed providers through partial or full integration, including multi-provider networks, hospital networks, physician-hospital organizations, and other efforts to provide health care services more efficiently.

(D) ACTIVITIES OF MEDICAL SELF-REGULATORY ENTITIES.—Permitting standard setting and enforcement activities by medical self-regulatory entities (such as hospital boards and medical societies) to promote health care quality, except that a safe harbor under this paragraph may not provide protection for any activ-

ity undertaken for financial gain or for anti-competitive reasons.

(E) PROVISION OF INFORMATION TO BUYERS AND CONSUMERS.—Permitting health care providers collectively to supply non-price medical information to buyers and consumers relating to the type, quality and efficiency of treatment, including joint views on procedures that should be covered by purchasers and medical protocols, except that a safe harbor under this subparagraph may not provide protection for any collective refusals to deal or collective attempts at coercion.

(F) PARTICIPATION IN SURVEYS.—Providing the terms under which health care providers may lawfully participate in written surveys of prices of services, reimbursements received, employee compensation, and other relevant areas.

(G) HIGH-TECHNOLOGY AND TERTIARY CARE JOINT VENTURES.—Permitting activities of health care joint ventures to purchase or use new or existing high technology or costly equipment, or to provide advanced tertiary care services.

(H) MARKET POWER SCREENS.—Providing market power screens at appropriate levels below which combinations of health care providers are too small to pose a realistic antitrust threat. There may be different levels for different activities and markets, taking into account the special needs of rural health care markets.

(I) JOINT PURCHASING ARRANGEMENTS.—Providing the terms under which health care providers may make joint purchases of products and services.

(J) GOOD FAITH NEGOTIATIONS.—Providing the terms under which health care providers may engage in discussions relating to legitimate collaborative activities contemplated by the safe harbors.

(b) PROCESS FOR DESIGNATION OF ADDITIONAL CATEGORIES OF ACTIVITIES.—

(1) SOLICITATION OF PROPOSALS.—Not later than 30 days after the date of the enactment of this Act, the Attorney General shall publish a notice in the Federal Register soliciting proposals for safe harbors.

(2) REVIEW OF PROPOSED SAFE HARBORS.—Not later than 180 days after the date of the enactment of this Act, the Attorney General (in consultation with the Secretary and the Chair) shall review the proposed safe harbors submitted under paragraph (1) and include a description of the safe harbors in the report under subsection (d).

(3) ADDITIONAL SAFE HARBORS.—After submitting the report under subsection (d), the Attorney General (in consultation with the Secretary and the Chair) may from time to time add additional safe harbors in accordance with the procedures described in this subsection.

(c) EFFECTIVE DATE OF SAFE HARBORS.—

(1) PUBLICATION.—Not later than 180 days after the date of the enactment of this Act, the Attorney General shall publish in the Federal Register for public comment the safe harbors proposed for designation under this section. Not later than 180 days after publishing such proposed safe harbors in the Federal Register, the Attorney General shall issue final rules establishing such safe harbors.

(2) EFFECTIVE DATE.—The safe harbors established under the final rules issued under paragraph

(1) shall take effect 90 days after issuance, unless disapproved by the Congress.

(d) REPORT ON PROPOSED SAFE HARBORS.—Not later than 180 days after the date of the enactment of this Act, the Attorney General (in consultation with the Secretary and the Chair) shall submit a report to Congress describing the proposals from subsections (a) and (b)(1) to be included in the publication of safe harbors described in subsection (c)(1) and the proposals from subsection (b)(1) that are not to be so included, together with explanations therefor.

(e) MODIFICATION OR REMOVAL OF SAFE HARBORS.—The Attorney General (in consultation with the Secretary and the Chair) may modify or remove a safe harbor following notice and comment upon a determination that the safe harbor does not meet the criteria of subsection (f).

(f) CRITERIA FOR SAFE HARBORS.—In establishing safe harbors under this section, the Attorney General shall take into account the following:

(1) The extent to which a competitive or collaborative activity will accomplish any of the following:

(A) An increase in access to health care services.

(B) The enhancement of the quality of health care services.

(C) The establishment of cost efficiencies that will be passed on to consumers, including economies of scale and reduced transaction and administrative costs.

(D) An increase in the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

(E) An improvement in the utilization of health care resources or the reduction in the inefficient duplication of the use of such resources.

(2) Whether the designation of an activity as a safe harbor will result in the following outcomes:

(A) Health plans and other health care insurers, consumers of health care services, and health care providers will be better able to negotiate payment and service arrangements which will reduce costs to consumers.

(B) Taking into consideration the characteristics of the particular purchasers and providers involved, competition will not be unduly restricted.

(C) Equally efficient and less restrictive alternatives do not exist to meet the criteria described in paragraph (1).

(D) The activity will not unreasonably foreclose competition by denying competitors a necessary element of competition.

SEC. 523. CERTIFICATES OF REVIEW.

(a) ESTABLISHMENT OF PROGRAM.—In consultation with the Secretary and the Chair, the Attorney General shall (not later than 180 days after the date of the enactment of this Act) issue certificates of review in accordance with this section for providers of health care services and advise and assist any person with respect to applying for such a certificate of review.

(b) PROCEDURES FOR APPLICATION FOR CERTIFICATE.—

(1) SUBMISSION OF APPLICATION.—

(A) FORM; CONTENT.—To apply for a certificate of review, a person shall submit to the Attorney General a written application which—

(i) specifies the activities relating to the provision of health care services which satisfy the criteria described in section 522(f) and which will be included in the certificate; and

(ii) is in a form and contains any information, including information pertaining to the overall market in which the applicant operates, required by rule or regulation promulgated under section 526.

(B) FILING FEE.—The Attorney General may require a filing fee to be submitted with the application to cover the cost of publication and the cost of review required by this section. The amount of the filing fee shall be determined on a sliding scale established by the Attorney General in consultation with the Chair (based on the monetary size of the transaction involved), except that such fee may not exceed $5,000.

(2) PUBLICATION OF NOTICE IN FEDERAL REGISTER.—Within 10 days after an application submitted under paragraph (1) is received by the Attorney General, the Attorney General shall publish in the Federal Register a notice that announces that an application for a certificate of review has been submitted, identifies each person submitting the application, and describes the conduct for which the application is submitted.

(3) ESTABLISHMENT OF PROCEDURES FOR ISSUANCE OF CERTIFICATE.—In consultation with the Chair and the Secretary, the Attorney General shall establish procedures to be used in applying for and in determining whether to approve an application for a certificate of review under this subtitle. Under such procedures the Attorney General, in consultation with the Secretary, shall approve an application if the Attorney General determines that the activities to be covered under the certificate will satisfy the criteria described in section 522(f) for safe harbors designated under such section and that the benefits of the issuance of the certificate will outweigh any disadvantages that may result from reduced competition. If the Attorney General, with the concurrence of the Secretary, determines that the requirements for a certificate are met, the Attorney General shall issue to the applicant a certificate of review. The certificate of review shall specify—

(i) the health care market activities to which the certificate applies,

(ii) the person to whom the certificate of review is issued, and

(iii) any terms and conditions the Attorney General or the Secretary deems nec-

essary to assure compliance with the applicable procedures described in paragraph (3).

(4) TIMING FOR DECISION ON APPLICATION.—Within 90 days after the Attorney General receives an application for a certificate of review, the Attorney General shall determine whether to grant or deny the certificate.

(5) NOTIFICATION OF DECISION.—The Attorney General shall notify the applicant of the Attorney General's determination and, if the application is denied, the reasons for the denial.

(6) FRAUDULENT PROCUREMENT.—A certificate of review shall be void ab initio with respect to any health care market activities for which the certificate was procured by fraud.

(c) AMENDMENT AND REVOCATION OF CERTIFICATES.—

(1) NOTIFICATION OF CHANGES.—Any applicant who receives a certificate of review—

(A) shall promptly report to the Attorney General any change relevant to the matters specified in the certificate; and

(B) may submit to the Attorney General an application to amend the certificate to re-

flect the effect of the change on the conduct specified in the certificate.

(2) AMENDMENT TO CERTIFICATE.—An application for an amendment to a certificate of review shall be treated as an application for the issuance of a certificate. The effective date of an amendment shall be the date on which the application for the amendment is received by the Attorney General.

(3) REVOCATION.—

(A) GROUNDS FOR REVOCATION.—In accordance with this paragraph, the Attorney General, in consultation with the Secretary, may revoke in whole or in part a certificate of review issued under this section based on one or more of the following grounds:

(i) After the expiration of the 2-year period beginning on the date a person's certificate is issued, the activities of the person have not substantially accomplished the purposes for the issuance of the certificate.

(ii) The person has failed to comply with any of the terms or conditions imposed under the certificate by the Attorney

General or the Secretary under subsection (b)(4).

(iii) The activities covered under the certificate no longer satisfy the criteria set forth in section 522(f).

(B) REQUEST FOR COMPLIANCE INFORMATION.—If the Attorney General or the Secretary has reason to believe that any of the grounds for revocation of a certificate of review described in subparagraph (A) may apply to a person holding the certificate, the Attorney General shall request such information from such person as the Attorney General or the Secretary deems necessary to resolve the matter of compliance. Failure to comply with such request shall be grounds for revocation of the certificate under this paragraph.

(C) PROCEDURES FOR REVOCATION.—If the Attorney General or the Secretary determines that any of the grounds for revocation of a certificate of review described in subparagraph (A) apply to a person holding the certificate, or that such person has failed to comply with a request made under subparagraph (B), the Attorney General shall give written notice of

the determination to such person. The notice shall include a statement of the circumstances underlying, and the reasons in support of, the determination. In the 60-day period beginning 30 days after the notice is given, the Attorney General shall revoke the certificate or modify it as the Attorney General or the Secretary deems necessary to cause the certificate to apply only to activities that meet the criteria set forth in section 522(f).

(D) INVESTIGATION AUTHORITY.—For purposes of carrying out this paragraph, the Attorney General may conduct investigations in the same manner as the Attorney General conducts investigations under section 3 of the Antitrust Civil Process Act, except that no civil investigative demand may be issued to a person to whom a certificate of review is issued if such person is the target of such investigation.

(d) REVIEW OF DETERMINATIONS.—

(1) AVAILABILITY OF REVIEW FOR CERTAIN ACTIONS.—If the Attorney General denies, in whole or in part, an application for a certificate of review or for an amendment to a certificate, or revokes or modifies a certificate pursuant to paragraph (3), the

applicant or certificate holder (as the case may be) may, within 30 days of the denial or revocation, bring an action in the United States District Court for the District of Columbia to set aside the determination on the ground that such determination is clearly erroneous.

(2) NO OTHER REVIEW PERMITTED.—Except as provided in paragraph (1), no action by the Attorney General, the Chair, or the Secretary pursuant to this subtitle shall be subject to judicial review.

(3) EFFECT OF REJECTED APPLICATION.—If the Attorney General denies, in whole or in part, an application for a certificate of review or for an amendment to a certificate, or revokes or amends a certificate, neither the negative determination nor the statement of reasons therefore shall be admissible in evidence, in any administrative or judicial proceeding, concerning any claim under the antitrust laws.

(e) PUBLICATION OF DECISIONS.—The Attorney General shall publish a notice in the Federal Register on a timely basis of each decision made with respect to an application for a certificate of review under this section or the amendment or revocation of such a certificate, in

a manner that protects the confidentiality of any proprietary information relating to the application.

(f) ANNUAL REPORTS.—Every person to whom a certificate of review is issued shall submit to the Attorney General an annual report, in such form and at such time as the Attorney General may require, that contains any necessary updates to the information required under subsection (b) and a description of the activities of the holder under the certificate during the preceding year.

(g) RESTRICTIONS ON DISCLOSURE OF INFORMATION.—

(1) WAIVER OF DISCLOSURE REQUIREMENTS UNDER ADMINISTRATIVE PROCEDURE ACT.—Information submitted by any person in connection with the issuance, amendment, or revocation of a certificate of review shall be exempt from disclosure under section 552 of title 5, United States Code.

(2) RESTRICTIONS ON DISCLOSURE OF COMMERCIAL OR FINANCIAL INFORMATION.—

(A) IN GENERAL.—Except as provided in subparagraph (B), no officer or employee of the United States shall disclose commercial or financial information submitted in connection with the issuance, amendment, or revocation of a certificate of review if the information is priv-

ileged or confidential or if disclosure of the information would cause harm to the person who submitted the information.

(B) EXCEPTIONS.—Subparagraph (A) shall not apply with respect to information disclosed—

(i) upon a request made by the Congress or any committee of the Congress,

(ii) in a judicial or administrative proceeding, subject to appropriate protective orders,

(iii) with the consent of the person who submitted the information,

(iv) in the course of making a determination with respect to the issuance, amendment, or revocation of a certificate of review, if the Attorney General deems disclosure of the information to be necessary in connection with making the determination,

(v) in accordance with any requirement imposed by a statute of the United States, or

(vi) in accordance with any rule or regulation promulgated under subsection

(i) permitting the disclosure of the information to an agency of the United States or of a State on the condition that the agency will disclose the information only under the circumstances specified in clauses (i) through (v).

(3) PROHIBITION AGAINST USE OF INFORMATION TO SUPPORT OR ANSWER CLAIMS UNDER ANTITRUST LAWS.—Any information disclosed in an application for a certificate of review under this section shall only be admissible into evidence in a judicial or administrative proceeding for the sole purpose of establishing whether a person is entitled to the protections provided by such a certificate.

SEC. 524. NOTIFICATIONS PROVIDING REDUCTION IN CERTAIN PENALTIES UNDER ANTITRUST LAW FOR HEALTH CARE JOINT VENTURES.

(a) NOTIFICATIONS DESCRIBED.—

(1) SUBMISSION OF NOTIFICATION BY VENTURE.—Any party to a health care joint venture, acting on such venture's behalf, may, not later than 90 days after entering into a written agreement to form such venture or not later than 90 days after the date of the enactment of this Act, whichever is

later, file with the Attorney General a written notification disclosing—

(A) the identities of the parties to such venture,

(B) the nature and objectives of such venture, and

(C) such additional information as the Attorney General may require by regulation.

(2) FILING FEE.—The Attorney General may require a filing fee to be submitted with the notification to cover the cost of publication and the cost of administering this section, except that the amount of such fee shall not exceed $250.

(3) SUBMISSION OF ADDITIONAL INFORMATION.—

(A) REQUEST OF ATTORNEY GENERAL.—At any time after receiving a notification filed under paragraph (1), the Attorney General may require the submission of additional information or documentary material relevant to the proposed health care joint venture.

(B) PARTIES TO VENTURE.—Any party to a health care joint venture may submit such additional information on the venture's behalf as may be appropriate to ensure that the venture

will receive the protections provided under subsection (b).

(C) REQUIRED SUBMISSION OF INFORMATION ON CHANGES TO VENTURE.—A health care joint venture for which a notification is in effect under this section shall submit information on any change in the membership of the venture not later than 90 days after such change occurs.

(4) PUBLICATION OF NOTIFICATION.—

(A) INFORMATION MADE PUBLICLY AVAILABLE.—Not later than 30 days after receiving a notification with respect to a venture under paragraph (1), the Attorney General shall publish in the Federal Register a notice with respect to the venture that identifies the parties to the venture and generally describes the purpose and planned activity of the venture. Prior to its publication, the contents of the notice shall be made available to the parties to the venture.

(B) RESTRICTION ON DISCLOSURE OF OTHER INFORMATION.—All information and documentary material submitted pursuant to this section and all information obtained by the

Attorney General in the course of any investigation or case with respect to a potential violation of the antitrust laws by the health care joint venture (other than information and material described in subparagraph (A)) shall be exempt from disclosure under section 552 of title 5, United States Code, and shall not be made publicly available by any agency of the United States to which such section applies except in a judicial proceeding in which such information and material is subject to any protective order.

(5) WITHDRAWAL OF NOTIFICATION.—Any person who files a notification pursuant to this section may withdraw such notification before a publication by the Attorney General pursuant to paragraph (4).

(6) NO JUDICIAL REVIEW PERMITTED.—Any action taken or not taken by the Attorney General with respect to notifications filed pursuant to this subsection shall not be subject to judicial review.

(b) PROTECTIONS FOR VENTURES SUBJECT TO NOTIFICATION.—

(1) IN GENERAL.—

(A) PROTECTIONS DESCRIBED.—Except as provided in subsection (c), the provisions of paragraphs (2), (3), (4), and (5) shall apply

with respect to any action under the antitrust laws challenging conduct within the scope of a notification which is in effect pursuant to subsection (a)(1).

(B) TIMING OF PROTECTIONS.—The protections described in this subsection shall apply to the venture that is the subject of a notification under subsection (a)(1) as of the earlier of—

(i) the date of the publication in the Federal Register of the notice published with respect to the notification; or

(ii) if such notice is not published during the period required under subsection (a)(4), the expiration of the 30-day period that begins on the date the Attorney General receives any necessary information required to be submitted under subsection (a)(1) or any additional information required by the Attorney General under subsection (a)(3)(A).

(2) APPLICABILITY OF RULE OF REASON STANDARD.—In any action under the antitrust laws, the conduct of any person which is within the scope of a notification filed under subsection (a) shall not

be deemed illegal per se, but shall be judged on the basis of its reasonableness, taking into account all relevant factors affecting competition, including, but not limited to, effects on competition in relevant markets.

(3) LIMITATION ON RECOVERY TO ACTUAL DAMAGES AND INTEREST.—Notwithstanding section 4 of the Clayton Act, any person who is entitled to recovery under the antitrust laws for conduct that is within the scope of a notification filed under subsection (a) shall recover the actual damages sustained by such person and interest calculated at the rate specified in section 1961 of title 28, United States Code, for the period beginning on the earliest date for which injury can be established and ending on the date of judgment, unless the court finds that the award of all or part of such interest is unjust under the circumstances.

(4) AWARD OF ATTORNEY'S FEES AND COSTS OF SUIT.—

(A) IN GENERAL.—In any action under the antitrust laws brought against a health care joint venture for conduct that is within the scope of a notification filed under subsection

(a), the court shall, at the conclusion of the action—

(i) award to a substantially prevailing claimant the cost of suit attributable to such claim, including a reasonable attorney's fee, or

(ii) award to a substantially prevailing party defending against such claim the cost of such suit attributable to such claim, including reasonable attorney's fee, if the claim, or the claimant's conduct during litigation of the claim, was frivolous, unreasonable, without foundation, or in bad faith.

(B) OFFSET IN CASES OF BAD FAITH.—The court may reduce an award made pursuant to subparagraph (A) in whole or in part by an award in favor of another party for any part of the cost of suit (including a reasonable attorney's fee) attributable to conduct during the litigation by any prevailing party that the court finds to be frivolous, unreasonable, without foundation, or in bad faith.

(5) RESTRICTIONS ON ADMISSIBILITY OF INFORMATION.—

(A) IN GENERAL.—Any information disclosed in a notification submitted under subsection (a)(1) and the fact of the publication of a notification by the Attorney General under subsection (a)(4) shall only be admissible into evidence in a judicial or administrative proceeding for the sole purpose of establishing whether a party to a health care joint venture is entitled to the protections described in this subsection.

(B) ACTIONS OF ATTORNEY GENERAL.—No action taken by the Attorney General pursuant to this section shall be admissible into evidence in any judicial or administrative proceeding for the purpose of supporting or answering any claim under the antitrust laws.

(c) EXCEPTION FOR CERTAIN ACTIVITIES.—In the event the parties cannot show procompetitive aspects necessary to the success of the joint venture, the protections described in subsection (b) should not be construed to apply to conduct which constitutes per se price-fixing, bid-rigging, or market allocation.

SEC. 525. REVIEW AND REPORTS ON SAFE HARBORS, CERTIFICATES OF REVIEW, AND NOTIFICATIONS.

(a) IN GENERAL.—The Attorney General, in consultation with the Secretary and the Chair, shall periodi-

cally review the safe harbors designated under section 522, the certificates of review issued under section 523, and notification received under section 524, and—

(1) with respect to the safe harbors, issue modifications to such safe harbors in such manner as the Attorney General considers appropriate in accordance with the requirements of section 522(f), which modifications shall take effect 90 days after issuance, unless disapproved by the Congress; and

(2) with respect to the certificates of review and notifications, submit a report to Congress on the issuance of such certificates and receipt of notifications, including a description of the effect of such certificates and notifications on increasing access to high quality health care services at reduced costs.

(b) RECOMMENDATIONS FOR LEGISLATION.—The Attorney General shall include in the reports submitted under subsection (a)(2) any recommendations of the Attorney General for legislation to improve the programs for the issuance of certificates of review and receipt of notifications established under this subtitle.

SEC. 526. RULES, REGULATIONS, AND GUIDELINES.

(a) SAFE HARBORS, CERTIFICATES, AND NOTIFICATIONS.—The Attorney General, in consultation with the Secretary and the Chair, shall promulgate such rules, reg-

ulations, and guidelines as are necessary to carry out sections 522, 523, and 524.

(b) GUIDANCE FOR PROVIDERS.—

(1) IN GENERAL.—To promote greater certainty regarding the application of the antitrust laws to activities in the health care market, the Attorney General, in consultation with the Secretary and the Chair, shall (not later than 1 year after the date of the enactment of this Act), taking into account the criteria used to designate safe harbors under section 522 and to grant certificates of review under section 523, publish guidelines—

(A) to define or provide assistance in determining relevant geographic and product markets for health care services and providers of health care services;

(B) to further collaborative activities which may be helpful to enhance services in underserved and geographically disadvantaged areas such as rural markets and inner cities;

(C) to assist collaboration between providers (such as hospital networks, physician-hospital organizations, and other groups of providers) which will help provide health care services more efficiently;

(D) to further activities by which public health clinics (including community health centers and migrant health centers under title III of the Public Health Service Act) may participate in networks and other collaborative activities in order to enhance services in underserved areas;

(E) to assist providers of health care services in analyzing whether the activities of such providers may be subject to a safe harbor under section 522;

(F) to provide clarification for activities in the general subject matter areas described in the safe harbors in section 522, but which fall outside the safe harbors; and

(G) to describe specific types of activities which would meet the requirements for issuance of a certificate of review under section 523, and summarizing the factual and legal bases on which the activities would meet the requirements.

(2) PERIODIC UPDATE.—The Attorney General shall periodically update the guidelines published under paragraph (1) as the Attorney General considers appropriate.

(3) WAIVER OF ADMINISTRATIVE PROCEDURE ACT.—Section 553 of title 5, United States Code, shall not apply to the issuance of guidelines under paragraph (1).

SEC. 527. DEFINITIONS.

In this subtitle, the following definitions shall apply:

(1) The term ''antitrust laws''—

(A) has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition; and

(B) includes any State law similar to the laws referred to in subparagraph (A).

(2) The term ''Chair'' means the Chair of the Federal Trade Commission.

(3) The term ''health benefit plan'' means any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance subscriber contract, or a multiple employer welfare arrangement or employee benefit plan (as defined under the Employee Retirement Income Security Act of 1974) which provides benefits with respect to health care services.

(4) The term ''health care joint venture'' means a joint venture of 2 or more persons formed for the purpose of providing health care services, including attempts to enter into or perform a contract or agreement to provide such services.

(5) The term ''health care services'' means any services for which payment may be made under a health benefit plan, including services related to the delivery or administration of such services.

(6) The term ''medical self-regulatory entity'' means a medical society or association, a specialty board, a recognized accrediting agency, or a hospital medical staff, and includes the members, officers, employees, consultants, and volunteers or committees of such an entity.

(7) The term ''person'' includes a State or unit of local government.

(8) The term ''provider of health care services'' means any individual or entity that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

(9) The term ''Secretary'' means the Secretary of Health and Human Services.

(10) The term ''specialty group'' means a medical specialty or subspecialty in which a provider of health care services may be licensed to practice by a State (as determined by the Secretary in consultation with the certification boards for such specialties and subspecialties).

(11) The term ''standard setting and enforcement activities'' means—

(A) accreditation of health care practitioners, health care providers, medical education institutions, or medical education programs,

(B) technology assessment and risk management activities,

(C) the development and implementation of practice guidelines or practice parameters, or

(D) official peer review proceedings undertaken by a hospital medical staff (or committee thereof) or a medical society or association for purposes of evaluating the professional conduct or quality of health care provided by a medical professional.

TITLE VI—ADMINISTRATIVE SIMPLIFICATION AND PRIVACY

SEC. 601. ADMINISTRATIVE SIMPLIFICATION.

(a) HEALTH INFORMATION NETWORK.—

(1) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new subtitle:

"Subtitle B—Administrative Simplification

"TABLE OF CONTENTS OF SUBTITLE

''PART I—PURPOSE AND DEFINITIONS

''SEC. 11701. PURPOSE.

''It is the purpose of this subtitle to improve the efficiency and effectiveness of the health care system, including the medicare program under title XVIII and the medicaid program under title XIX, by encouraging the development of a health information network through the establishment of standards and requirements for the electronic transmission of certain health information.

''SEC. 11702. DEFINITIONS.

''For purposes of this subtitle:

''(1) CODE SET.—The term 'code set' means any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

''(2) COORDINATION OF BENEFITS.—The term 'coordination of benefits' means determining and coordinating the financial obligations of health plans

when health care benefits are payable under 2 or more health plans.

''(3) HEALTH CARE PROVIDER.—The term 'health care provider' includes a provider of services (as defined in section 1861(u)), a provider of medical or other health services (as defined in section 1861(s)), and any other person furnishing health care services or supplies.

''(4) HEALTH INFORMATION.—The term 'health information' means any information, whether oral or recorded in any form or medium that—

''(A) is created or received by a health care provider, health plan, health oversight agency (as defined in section 11802), health researcher, public health authority (as defined in section 11802), employer, life insurer, school or university, or health information network service certified under section 11741; and

''(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

''(5) HEALTH INFORMATION NETWORK.—The term 'health information network' means the health

information system that is formed through the application of the requirements and standards established under this subtitle.

''(6) HEALTH INFORMATION PROTECTION ORGANIZATION.—The term 'health information protection organization' means a private entity or an entity operated by a State that accesses standard data elements of health information through the health information network, processes such information into non-identifiable health information, and may store such information.

''(7) HEALTH INFORMATION NETWORK SERVICE.—The term 'health information network service'—

''(A) means a private entity or an entity operated by a State that enters into contracts to—

''(i) process or facilitate the processing of nonstandard data elements of health information into standard data elements;

''(ii) provide the means by which persons are connected to the health information network for purposes of meeting the requirements of this subtitle, including the

holding of standard data elements of health information;

''(iii) provide authorized access to health information through the health information network; or

''(iv) provide specific information processing services, such as automated coordination of benefits and claims transaction routing; and

''(B) includes a health information protection organization.

''(8) HEALTH PLAN.—The term 'health plan' has the meaning given such term in section 21003(a)(1) except that such term shall include subparagraphs (C), (D), (E), (F), and (H) of such section.

''(9) NON-IDENTIFIABLE HEALTH INFORMATION.—The term 'non-identifiable health information' means health information that is not protected health information as defined in section 11802.

''(10) HEALTH RESEARCHER.—The term 'health researcher' shall have the meaning given such term under section 11802.

''(11) PATIENT MEDICAL RECORD INFORMATION.—The term 'patient medical record informa-

tion' means health information derived from a clinical encounter that relates to the physical or mental condition of an individual.

''(12) STANDARD.—The term 'standard' when referring to an information transaction or to data elements of health information means the transaction or data elements meet any standard adopted by the Secretary under part II that applies to such information transaction or data elements.

"PART II—STANDARDS FOR DATA ELEMENTS AND INFORMATION TRANSACTIONS

"SEC. 11711. GENERAL REQUIREMENTS ON SECRETARY.

''(a) IN GENERAL.—The Secretary shall adopt standards and modifications to standards under this subtitle that are—

''(1) consistent with the objective of reducing the costs of providing and paying for health care; and

''(2) in use and generally accepted or developed or modified by the standards setting organizations accredited by the American National Standard Institute (ANSI).

''(b) INITIAL STANDARDS.—The Secretary may develop an expedited process for the adoption of initial standards under this subtitle.

''(c) PAPER FORMATS.—The Secretary may develop methods by which a person may use the standards adopted by the Secretary under this subtitle with respect to health information that is in written rather than electronic form.

"SEC. 11712. STANDARDS FOR DATA ELEMENTS OF HEALTH INFORMATION.

''(a) IN GENERAL.—The Secretary shall adopt standards necessary to make data elements of the following health information uniform and compatible for electronic transmission through the health information network:

''(1) the health information that is appropriate for transmission in connection with transactions described in subsections (a) and (b) of section 11721;

''(2) any quality information required to be submitted by a health plan to a State under title XXI; and

''(3) patient medical record information.

''(b) ADDITIONS.—The Secretary may make additions to the sets of data elements adopted under subsection (a) as the Secretary determines appropriate in a manner that minimizes the disruption and cost of compliance with such additions.

''(c) CERTAIN DATA ELEMENTS.—

''(1) UNIQUE HEALTH IDENTIFIERS.—The Secretary shall adopt standards for a standard unique

health identifier for each individual, employer, health plan, and health care provider for use in the health care system.

''(2) CODE SETS.—

''(A) IN GENERAL.—The Secretary, in consultation with experts from the private sector and Federal agencies, shall—

''(i) select code sets for appropriate data elements from among the code sets that have been developed by private and public entities; or

''(ii) establish code sets for such data elements if no code sets for the data elements have been developed.

''(B) DISTRIBUTION.—The Secretary shall establish efficient and low-cost procedures for distribution of code sets and modifications to such code sets under section 11714(c).

''SEC. 11713. INFORMATION TRANSACTION STANDARDS.

''(a) IN GENERAL.—The Secretary shall adopt technical standards relating to the method by which data elements of health information that have been standardized under section 11712 may be transmitted electronically, including standards with respect to the format in which such data elements shall be transmitted.

''(b) SPECIAL RULE FOR COORDINATION OF BENEFITS.—Any standards adopted by the Secretary under paragraph (1) that relate to coordination of benefits shall provide that a claim for reimbursement for medical services furnished is tested by an algorithm specified by the Secretary against all records of enrollment and eligibility for the individual who received such services to determine any primary and secondary obligors for payment.

''(c) ELECTRONIC SIGNATURE.—The Secretary, in coordination with the Secretary of Commerce, shall promulgate regulations specifying procedures for the electronic transmission and authentication of signatures, compliance with which will be deemed to satisfy State and Federal statutory requirements for written signatures with respect to information transactions required by this Act and written signatures on medical records and prescriptions.

"SEC. 11714. TIMETABLES FOR ADOPTION OF STANDARDS.

''(a) INITIAL STANDARDS FOR DATA ELEMENTS.—The Secretary shall adopt standards relating to—

''(1) the data elements for the information described in section 11712(a)(1) not later than 9 months after the date of the enactment of this subtitle (except in the case of standards with respect to data elements for claims attachments which shall be

adopted not later than 24 months after the date of the enactment of this subtitle);

''(2) the data elements for the information described in section 11712(a)(2) not later than 9 months after the date of the enactment of this subtitle;

''(3) data elements for patient medical record information not earlier than 5 years and not later than 10 years after the date of the enactment of this subtitle; and

''(4) any addition to a set of data elements, in conjunction with making such an addition.

''(b) INITIAL STANDARDS FOR INFORMATION TRANSACTIONS.—The Secretary shall adopt standards relating to information transactions under section 11713 not later than 9 months after the date of the enactment of this subtitle (except in the case of standards for claims attachments which shall be adopted not later than 24 months after the date of the enactment of this subtitle).

''(c) MODIFICATIONS TO STANDARDS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall review the standards adopted under this subtitle and shall adopt modified standards as determined appropriate, but no more frequently than once every 6 months. Any modifica-

tion to standards shall be completed in a manner which minimizes the disruption and cost of compliance.

''(2) SPECIAL RULES.—

''(A) MODIFICATIONS DURING FIRST 12-MONTH PERIOD.—Except with respect to additions and modifications to code sets under subparagraph (B), the Secretary shall not adopt any modifications to standards adopted under this subtitle during the 12-month period beginning on the date such standards are adopted unless the Secretary determines that a modification is necessary in order to permit compliance with requirements relating to the standards.

''(B) ADDITIONS AND MODIFICATIONS TO CODE SETS.—

''(i) IN GENERAL.—The Secretary shall ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets to accommodate changes in biomedical science and health care delivery.

''(ii) ADDITIONAL RULES.—If a code set is modified under this subsection, the

modified code set shall include instructions on how data elements that were encoded prior to the modification are to be converted or translated so as to preserve the value of the data elements. Any modification to a code set under this subsection shall be implemented in a manner that minimizes the disruption and cost of complying with such modification.

''(d) EVALUATION OF STANDARDS.—The Secretary may establish a process to measure or verify the consistency of standards adopted or modified under this subtitle. Such process may include demonstration projects and analysis of the cost of implementing such standards and modifications.

"PART III—REQUIREMENTS WITH RESPECT TO CERTAIN TRANSACTIONS AND INFORMATION

"SEC. 11721. REQUIREMENTS WITH RESPECT TO CERTAIN TRANSACTIONS AND INFORMATION.

''(a) REQUIREMENTS ON PLANS AND PROVIDERS RELATING TO FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.—If a health care provider or a health plan conducts any of the following transactions, such transactions shall be standard transactions and the information trans-

mitted or received in connection with such transaction shall be in the form of standard data elements:

''(1) Claims (including coordination of benefits).

''(2) Claims attachments.

''(3) Responses to research inquiries by a health researcher.

''(3) Other transactions determined appropriate by the Secretary consistent with the goal of reducing administrative costs.

''(b) REQUIREMENT ONLY ON PLANS RELATING TO FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.—If a person desires to conduct any of the following transactions with a health plan as a standard transaction, the health plan shall conduct such standard transaction and the information transmitted or received in connection with such transaction shall be in the form of standard data elements:

''(1) Enrollment and disenrollment.

''(2) Eligibility.

''(3) Payment and remittance advice.

''(4) Premium payments.

''(5) First report of injury.

''(6) Claims status.

''(7) Referral certification and authorization.

''(8) Other transactions determined appropriate by the Secretary consistent with the goal of reducing administrative costs.

''(c) REQUIREMENT ON PLANS RELATING TO QUALITY INFORMATION.—Any quality information required to be submitted by a health plan to a State under title XXI shall be in the form of standard data elements and the transmission of such data shall be in the form of a standard transaction.

''(d) REQUIREMENT WITH RESPECT TO DISCLOSURE OF INFORMATION.—

''(1) IN GENERAL.—A health plan or health care provider shall make the standard data elements transmitted or received by such plan or provider in connection with the transactions described in subsections (a), (b), and (c) or acquired under section 11764(a) available for disclosure as authorized by this subtitle.

''(2) SPECIAL RULE.—In the case of a health care provider that does not file claims, such provider shall be responsible for making standard data elements for encounter information available for disclosure as authorized by this subtitle.

''(e) SATISFACTION OF REQUIREMENTS.—A health care provider or health plan may satisfy the requirement

imposed on such provider or plan under subsection (a), (b), (c), or (d) by—

''(1) directly transmitting standard data elements;

''(2) submitting nonstandard data elements to a health information network service certified under section 11741 for processing into standard data elements and transmission; or

''(3) in the case of a provider, submitting data elements to a plan which satisfies the requirements imposed on such provider on the provider's behalf.

''(f) TIMELINESS.—A health care provider or health plan shall be determined to have satisfied a requirement imposed under this section only if the action required is completed in a timely manner, as determined by the Secretary. In setting standards for timeliness, the Secretary shall take into consideration the age and the amount of information being requested.

"SEC. 11722. TIMETABLES FOR COMPLIANCE WITH REQUIREMENTS.

''(a) INITIAL COMPLIANCE.—

''(1) IN GENERAL.—Not later than 12 months after the date on which standards are adopted under part II with respect to a type of transaction or data elements for a type of health information, a health

plan or health care provider shall comply with the requirements of this subtitle with respect to such transaction or information.

''(2) ADDITIONAL DATA ELEMENTS.—Not later than 12 months after the date on which the Secretary adopts an addition to a set of data elements for health information under part II, a health plan or health care provider shall comply with the requirements of this subtitle using such data elements.

''(b) COMPLIANCE WITH MODIFIED STANDARDS.—

''(1) IN GENERAL.—If the Secretary adopts a modified standard under part II, a health plan or health care provider shall be required to comply with the modified standard at such time as the Secretary determines appropriate taking into account the time needed to comply due to the nature and extent of the modification.

''(2) SPECIAL RULE.—In the case of modifications to standards that do not occur within the 12-month period beginning on the date such standards are adopted, the time determined appropriate by the Secretary under paragraph (1) shall be no sooner than the last day of the 90-day period beginning on the date such modified standard is adopted and no

later than the last day of the 12 month period beginning on the date such modified standard is adopted.

"PART IV—ACCESSING HEALTH INFORMATION

"SEC. 11731. ACCESSING HEALTH INFORMATION FOR AUTHORIZED PURPOSES.

''(a) IN GENERAL.—The Secretary shall adopt technical standards for appropriate persons, including health plans, health care providers, health information network services certified under section 11741, health researchers, and Federal and State agencies, to locate and access the health information that is available through the health information network due to the requirements of this subtitle. Such technical standards shall ensure that any request to locate or access information shall be authorized under subtitle C.

''(b) PROCUREMENT RULE FOR GOVERNMENT AGENCIES.—

''(1) IN GENERAL.—Health information protection organizations certified under section 11741 shall make available to a Federal or State agency pursuant to a Federal Acquisition Regulation (or an equivalent State system), any non-identifiable health information that is requested by such agency.

''(2) CERTAIN INFORMATION AVAILABLE AT LOW COST.—If a health information protection orga-

nization described in paragraph (1) needs information from a health plan or health care provider in order to comply with a request of a Federal or State agency that is necessary to comply with a requirement under this Act, such plan or provider shall make such information available to such organization for a charge that does not exceed the reasonable cost of transmitting the information. If requested, a health information protection organization that receives information under the preceding sentence must make such information available to any other such organization that is certified under section 11741 for a charge that does not exceed the reasonable cost of transmitting the information.

''(c) FUNCTIONAL SEPARATION.—The standards adopted by the Secretary under subsection (a) shall ensure that any health information disclosed under such subsection shall not, after such disclosure, be used or released for an administrative, regulatory, or law enforcement purpose unless such disclosure was made for such purpose.

''(d) PUBLIC USE FUNCTIONS.—Nothing in this subtitle shall be construed to limit the authority of a Federal or State agency to make non-identifiable health information available for public use functions.

"SEC. 11732. RESPONDING TO ACCESS REQUESTS.

''(a) IN GENERAL.—The Secretary may adopt, and modify as appropriate, standards under which a health care provider or health plan shall respond to requests for access to health information consistent with this subtitle and subtitle C.

''(b) STANDARDS DESCRIBED.—The standards under subsection (a) shall provide—

''(1) for a standard format under which a provider or plan will respond to each request either by satisfying the request or responding with an explanation of the specific restriction which results in a failure to satisfy the request; and

''(2) that any restrictions will not prevent a plan or provider from responding to a request in a timely manner taking into account the age and amount of the information being requested.

''(c) CONSTRUCTION.—Nothing in this section shall be construed as permitting a health care provider or health plan to refuse to disclose any health information that is required to be disclosed by law.

"SEC. 11733. LENGTH OF TIME INFORMATION SHOULD BE ACCESSIBLE.

''The Secretary shall adopt standards with respect to the length of time any standard data elements for a type

of health information should be accessible through the health information network.

"SEC. 11734. TIMETABLES FOR ADOPTION OF STANDARDS AND COMPLIANCE.

''(a) INITIAL STANDARDS.—The Secretary shall adopt standards under this part not later than 9 months after the date of the enactment of this subtitle and such standards shall be effective upon adoption.

''(b) MODIFICATIONS TO STANDARDS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall review the standards adopted under this part and shall adopt modified standards as determined appropriate, but no more frequently than once every 6 months. Any modification to standards shall be completed in a manner which minimizes the disruption and cost of compliance. Any modifications to standards adopted under this part shall be effective upon adoption.

''(2) SPECIAL RULE.—The Secretary shall not adopt modifications to any standards adopted under this part during the 12-month period beginning on the date such standards are adopted unless the Secretary determines that a modification is necessary in order to permit compliance with the requirements of this part.

"PART V—STANDARDS AND CERTIFICATION FOR HEALTH INFORMATION NETWORK

"SEC. 11741. STANDARDS AND CERTIFICATION FOR HEALTH INFORMATION NETWORK SERVICES.

''(a) STANDARDS FOR OPERATION.—The Secretary shall adopt standards with respect to the operation of health information network services to ensure that—

''(1) such services cooperate with one another to form the health information network;

''(2) such services meet all of the requirements under subtitle C that are applicable to such services;

''(3) such services make public information concerning their performance, as measured by uniform indicators such as accessibility, transaction responsiveness, administrative efficiency, reliability, dependability, and any other indicator determined appropriate by the Secretary;

''(4) such services have security procedures that are consistent with the privacy requirements under subtitle C, including secure methods of access to and transmission of data;

''(5) such services, if they are part of a larger organization, have policies and procedures in place which isolate their activities with respect to processing information in a manner that prevents unauthor-

ized access to such information by such larger organization.

''(b) CERTIFICATION BY THE SECRETARY.—

''(1) ESTABLISHMENT.—Not later than 12 months after the date of the enactment of this subtitle, the Secretary shall establish a certification procedure for health information network services which ensures that certified services are qualified to meet the requirements of this subtitle and the standards established by the Secretary under this section. Such certification procedure shall be implemented in a manner that minimizes the costs and delays of operations for such services.

''(2) APPLICATION.—Each entity desiring to be certified as a health information network service shall apply to the Secretary for certification in a form and manner determined appropriate by the Secretary.

''(3) AUDITS AND REPORTS.—The procedure established under paragraph (1) shall provide for audits by the Secretary and reports by an entity certified under this section as the Secretary determines appropriate in order to monitor such entity's compliance with the requirements of this subtitle, subtitle

C, and the standards established by the Secretary under this section.

''(c) LOSS OF CERTIFICATION.—

''(1) MANDATORY TERMINATION.—Except as provided in paragraph (3), if a health information network service violates a requirement imposed on such service under subtitle C, its certification under this section shall be terminated unless the Secretary determines that appropriate corrective action has been taken.

''(2) DISCRETIONARY TERMINATION.—If a health information network service violates a requirement or standard imposed under this subtitle and a penalty has been imposed under section 11751, the Secretary shall review the certification of such service and may terminate such certification.

''(3) CONDITIONAL CERTIFICATION—The Secretary may establish a procedure under which a health information network service may remain certified on a conditional basis if the service is operating consistently with a plan intended to correct any violations described in paragraphs (1) or (2). Such procedure may provide for the appointment of a trustee to continue operation of the service until the requirements for full certification are met.

''(d) CERTIFICATION BY PRIVATE ENTITIES.—The Secretary shall designate private entities to conduct the certification procedures established by the Secretary under this section. A health information network service certified by such an entity in accordance with such designation shall be considered to be certified by the Secretary.

"SEC. 11742. ENSURING AVAILABILITY OF INFORMATION.

''The Secretary shall establish a procedure under which a health plan or health care provider which does not have the ability to transmit standard data elements directly or does not have access to a health information network service certified under section 11741 shall be able to make health information available for disclosure as authorized by this subtitle.

"PART VI—PENALTIES

"SEC. 11751. GENERAL PENALTY FOR FAILURE TO COMPLY WITH REQUIREMENTS AND STANDARDS.

''(a) IN GENERAL.—Except as provided in subsection (b), the Secretary shall impose on any person that violates a requirement or standard imposed under this subtitle a penalty of not more than $1,000 for each violation. The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil money penalty under this

subsection in the same manner as such provisions apply to the imposition of a penalty under section 1128A.

''(b) LIMITATIONS.—

''(1) NONCOMPLIANCE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—A penalty may not be imposed under subsection (a) if it is established to the satisfaction of the Secretary that the person liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person failed to comply with the requirement or standard described in subsection (a).

''(2) FAILURES DUE TO REASONABLE CAUSE.—

''(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), a penalty may not be imposed under subsection (a) if—

''(i) the failure to comply was due to reasonable cause and not to willful neglect; and

''(ii) the failure to comply is corrected during the 30-day period beginning on the 1st date the person liable for the penalty knew, or by exercising reasonable diligence would have known, that the failure to comply occurred.

''(B) EXTENSION OF PERIOD.—

''(i) NO PENALTY.—The period referred to in subparagraph (A)(ii) may be extended as determined appropriate by the Secretary based on the nature and extent of the failure to comply.

''(ii) ASSISTANCE.—If the Secretary determines that a health plan or health care provider failed to comply because such person was unable to comply, the Secretary may provide technical assistance to such person. Such assistance shall be provided in any manner determined appropriate by the Secretary.

''(3) REDUCTION.—In the case of a failure to comply which is due to reasonable cause and not to willful neglect, any penalty under subsection (a) that is not entirely waived under paragraph (2) may be waived to the extent that the payment of such penalty would be excessive relative to the compliance failure involved.

"PART VII—MISCELLANEOUS PROVISIONS

"SEC. 11761. IMPOSITION OF ADDITIONAL REQUIREMENTS.

''(a) DATA ELEMENT STANDARDS.—A person may not impose a standard on another person that is in addi-

tion to the standards adopted by the Secretary under section 11712 unless—

''(1) such person voluntarily agrees to such standard; or

''(2) a waiver is granted under subsection (c) to impose such standard.

''(b) TRANSACTIONS AND ACCESS STANDARDS.—A person may not impose a standard on another person that is in addition to the standards adopted by the Secretary under section 11713 or 11731 unless such person voluntarily agrees to such standard.

''(c) CONDITIONS FOR WAIVERS.—

''(1) IN GENERAL.—A person may request a waiver from the Secretary in order to require another person to comply with a standard that is in addition to the standards adopted by the Secretary under section 11712.

''(2) CONSIDERATION OF WAIVER REQUESTS.—No waiver may be granted unless the Secretary determines that the value of the data to be exchanged for research or other purposes significantly outweighs the administrative cost of the additional standard taking into consideration the burden of the timing of the imposition of the additional standard.

''(3) ANONYMOUS REPORTING.—If a person attempts to impose a standard in addition to the standards adopted by the Secretary under section 11712, the person on whom such additional standard is being imposed may contact the Secretary. The Secretary shall develop a procedure under which the contacting person shall remain anonymous. The Secretary shall notify the person imposing the additional standard that the additional standard may not be imposed unless the other person voluntarily agrees to such standard or a waiver is obtained under this subsection.

"SEC. 11762. EFFECT ON STATE LAW.

''(a) IN GENERAL.—A provision, requirement, or standard under this subtitle shall supersede any contrary provision of State law, including—

''(1) a provision of State law that requires medical or health plan records (including billing information) to be maintained or transmitted in written rather than electronic form, and

''(2) a provision of State law which provides for requirements or standards that are more stringent than the requirements or standards under this subtitle;

except where the Secretary determines that the provision is necessary to prevent fraud and abuse, with respect to controlled substances, or for other purposes.

''(b) PUBLIC HEALTH REPORTING.—Nothing in this subtitle shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.

"SEC. 11764. HEALTH INFORMATION CONTINUITY.

''(a) INFORMATION HELD BY HEALTH PLANS AND PROVIDERS.—If a health plan or health care provider takes any action that would threaten the continued availability of the standard data elements of health information held by such plan or provider, such data elements shall be obtained by the State in which such plan or provider is located. The State shall ensure that such data elements are transferred to a health plan or health care provider in accordance with procedures established by the Secretary.

''(b) INFORMATION HELD BY HEALTH INFORMATION NETWORK SERVICES.—If a health information network service certified under section 11741 loses its certified status or takes any action that would threaten the continued availability of the standard data elements of health infor-

mation held by such service, such data elements shall be transferred to another health information network service certified under section 11741, as designated by the Secretary.

''SEC. 11765. PROTECTION OF COMMERCIAL INFORMATION.

''In adopting standards under this subtitle, the Secretary shall not require disclosure of trade secrets and confidential commercial information by entities operating in the health information network except as required by law.

''SEC. 11766. PAYMENT FOR HEALTH CARE SERVICES OR HEALTH PLAN PREMIUMS.

''Nothing in this subtitle shall be construed to prohibit payments for health care services or health plan premiums from being made by debit, credit, or other payment cards or numbers or other electronic payment means.

''SEC. 11767. HEALTH SECURITY CARDS.

''The Secretary shall adopt standards relating to the form of any health security cards that a health plan may issue and the information to be encoded electronically on such cards.

''SEC. 11768. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this subtitle.

"PART VIII—ASSISTANCE TO THE SECRETARY

"SEC. 11771. GENERAL REQUIREMENT ON SECRETARY.

''In complying with any requirements imposed under this subtitle, the Secretary shall rely on recommendations of the Health Information Advisory Committee established under section 11772 and shall consult with appropriate Federal agencies.

"SEC. 11772. HEALTH INFORMATION ADVISORY COMMITTEE.

''(a) ESTABLISHMENT.—There is established a committee to be known as the Health Care Information Advisory Committee.

''(b) DUTY.—

''(1) IN GENERAL.—The committee shall—

''(A) provide assistance to the Secretary in complying with the requirements imposed on the Secretary under this subtitle and subtitle C;

''(B) be generally responsible for advising the Secretary and the Congress on the status of the health information network; and

''(C) make recommendations to correct any problems that may occur in the network's implementation and ongoing operations and to refine and improve the network.

''(2) TECHNICAL ASSISTANCE.—In performing its duties under this subsection, the committee shall

receive technical assistance from appropriate Federal agencies.

''(c) MEMBERSHIP.—

''(1) IN GENERAL.—The committee shall consist of 15 members to be appointed by the President not later than 60 days after the date of the enactment of this subtitle. The President shall designate 1 member as the Chair.

''(2) EXPERTISE.—The membership of the committee shall consist of individuals who are of recognized standing and distinction and who possess the demonstrated capacity to discharge the duties imposed on the committee.

''(3) TERMS.—Each member of the committee shall be appointed for a term of 5 years, except that the members first appointed shall serve staggered terms such that the terms of no more than 3 members expire at one time.

''(4) VACANCIES.—

''(A) IN GENERAL.—A vacancy on the committee shall be filled in the manner in which the original appointment was made and shall be subject to any conditions which applied with respect to the original appointment.

''(B) FILLING UNEXPIRED TERM.—An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member replaced.

''(C) EXPIRATION OF TERMS.—The term of any member shall not expire before the date on which the member's successor takes office.

''(5) CONFLICTS OF INTEREST.—Members of the committee shall disclose upon appointment to the committee or at any subsequent time that it may occur, conflicts of interest.

''(d) MEETINGS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the committee shall meet at the call of the Chair.

''(2) INITIAL MEETING.—Not later than 30 days after the date on which all members of the committee have been appointed, the committee shall hold its first meeting.

''(3) QUORUM.—A majority of the members of the committee shall constitute a quorum, but a lesser number of members may hold hearings.

''(e) POWER TO HOLD HEARINGS.—The committee may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as

the committee considers advisable to carry out the purposes of this section.

''(f) OTHER ADMINISTRATIVE PROVISIONS.—Subparagraphs (C), (D), and (H) of section 1886(e)(6) shall apply to the committee in the same manner as they apply to the Prospective Payment Assessment Commission.

''(g) REPORTS.—

''(1) IN GENERAL.—The committee shall annually prepare and submit to Congress and the Secretary a report including at least an analysis of—

''(A) the status of the health information network established under this subtitle, including whether the network is fulfilling the purpose described in section 11701;

''(B) the savings and costs of the network;

''(C) the activities of health information network services certified under section 11741, health care providers, health plans, and other entities using the network to exchange health information;

''(D) the extent to which entities described in subparagraph (C) are meeting the standards adopted under this subtitle and working together to form an integrated network that meets the needs of its users;

''(E) the extent to which entities described in subparagraph (C) are meeting the privacy and security protections of subtitle C;

''(F) the number and types of penalties assessed for noncompliance with the standards adopted under this subtitle;

''(G) whether the Federal Government and State Governments are receiving information of sufficient quality to meet their responsibilities under the America's Health Care Option Act;

''(H) any problems with respect to implementation of the network;

''(I) the extent to which timetables under this subtitle for the adoption and implementation of standards are being met; and

''(J) any legislative recommendations related to the health information network.

''(2) AVAILABILITY TO THE PUBLIC.—Any information in the report submitted to Congress under paragraph (1) shall be made available to the public unless such information may not be disclosed by law.

''(h) DURATION.—Notwithstanding section 14(a) of the Federal Advisory Committee Act, the committee shall continue in existence until otherwise provided by law.

''(i) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.

''(2) AVAILABILITY.—Any sums appropriated under the authorization contained in this subsection shall remain available, without fiscal year limitation, until expended.

"PART IX—DEMONSTRATION PROJECTS FOR COMMUNITY-BASED CLINICAL INFORMATION SYSTEMS

"SEC. 11781. GRANTS FOR DEMONSTRATION PROJECTS.

''(a) IN GENERAL.—The Secretary may make grants for demonstration projects to promote the development and use of electronically integrated community-based clinical information systems and computerized patient medical records.

''(b) APPLICATIONS.—

''(1) SUBMISSION.—To apply for a grant under this part for any fiscal year, an applicant shall submit an application to the Secretary in accordance with the procedures established by the Secretary.

''(2) CRITERIA FOR APPROVAL.—The Secretary may not approve an application submitted under paragraph (1) unless the application includes assur-

ances satisfactory to the Secretary regarding the following:

''(A) USE OF EXISTING TECHNOLOGY.—Funds received under this part will be used to apply telecommunications and information systems technology that is in existence on the date the application is submitted in a manner that improves the quality of health care, reduces the costs of such care, and protects the privacy and confidentiality of information relating to the physical or mental condition of an individual.

''(B) USE OF EXISTING INFORMATION SYSTEMS.—Funds received under this part will be used—

''(i) to enhance telecommunications or information systems that are operating on the date the application is submitted;

''(ii) to integrate telecommunications or information systems that are operating on the date the application is submitted; or

''(iii) to connect additional users to telecommunications or information networks or systems that are operating on the date the application is submitted.

''(C) MATCHING FUNDS.—The applicant shall make available funds for the demonstration project in an amount that equals at least 20 percent of the cost of the project.

''(c) GEOGRAPHIC DIVERSITY.—In making any grants under this part, the Secretary shall, to the extent practicable, make grants to persons representing different geographic areas of the United States, including urban and rural areas.

''(d) REVIEW AND SANCTIONS.—The Secretary shall review at least annually the compliance of a person receiving a grant under this part with the provisions of this part. The Secretary shall establish a procedure for determining whether such a person has failed to comply substantially within the provisions of this part and the sanctions to be imposed for any such noncompliance.

''(e) ANNUAL REPORT.—The Secretary shall submit an annual report to the President for transmittal to Congress containing a description of the activities carried out under this part.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.''.

(2) Conforming amendments.—(A) Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is

amended by striking the title and inserting the following:

"TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION

"Subtitle A—General Provisions and Peer Review"

(B) Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by striking each reference to ''this title'' and inserting ''this subtitle''.

(b) MEDICARE AND MEDICAID COVERAGE DATA BANK AND RELATED IDENTIFICATION PROCESSES.—

(1) DELAY OF EMPLOYER REPORTING REQUIREMENT.—

(A) IN GENERAL.—Section 1144(c)(1)(A) of the Social Security Act (42 U.S.C. 1320–14(c)(1)(A)) is amended by striking ''January 1, 1994'' and inserting ''January 1, 1996''.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall be effective on the date of the enactment of this Act.

(2) REPEAL OF DATA BANK.—

(A) IN GENERAL.—Section 1144 of the Social Security Act (42 U.S.C. 1320b–14) and

section 101(f) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021(f)) are repealed.

(B) INTERNAL REVENUE CODE PROVISION.—Section 6103(*l*) of the Internal Revenue Code of 1986 is amended by striking paragraph (12).

(C) IDENTIFICATION OF MEDICARE SECONDARY PAYER SITUATIONS.—Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) is amended by striking paragraph (5).

(D) CONFORMING AMENDMENTS.—(i) Section 1902(a)(25)(A)(i) of the Social Security Act (42 U.S.C. 1396a(a)(25)(A)(i)) is amended by striking ''including the use of information collected by the Medicare and Medicaid Coverage Data Bank under section 1144 and any additional measures''.

(ii) Subsection (a)(8)(B) of section 552a of title 5, United States Code, is amended—

(I) in clause (v), by inserting ''; or'' at the end;

(II) in clause (vi), by striking ''or'' at the end; and

(III) by striking clause (vii).

(E) EFFECTIVE DATE.—The amendments made by this paragraph apply after the date on which the health information network established under subsection (a) is capable of replacing the activities performed under the provisions affected by such amendments, as certified by the Secretary of Health and Human Services.

SEC. 602. PRIVACY OF HEALTH INFORMATION UNDER THE SOCIAL SECURITY ACT.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 601, is amended by adding at the end the following new subtitle:

"Subtitle C—Privacy of Health Information

"TABLE OF CONTENTS OF SUBTITLE

"PART I—FINDINGS AND DEFINITIONS

"SEC. 11801. FINDINGS AND PURPOSES.

''(a) FINDINGS.—The Congress finds as follows:

''(1) The improper disclosure of individually identifiable health care information may cause significant harm to an individual's interests in privacy, health care, and reputation and may unfairly affect the ability of an individual to obtain employment, education, insurance, and credit.

''(2) The movement of people and health care related information across State lines, the availability of, access to, and exchange of health care related information with Federally funded health care systems, the medicare program under title XVIII, and the medicaid program under title XIX, through automated data banks and networks, and the emergence of other multistate health care providers and payors create a need for a uniform Federal law governing the disclosure of health care information.

''(b) PURPOSE.—The purpose of this subtitle is to establish effective mechanisms to protect the privacy of indi-

viduals with respect to individually identifiable health care information that is created or maintained as part of health treatment, enrollment, payment, testing, or research processes.

"SEC. 11802. DEFINITIONS.

''(a) TERMS RELATING TO PROTECTED HEALTH INFORMATION.—In this subtitle:

''(1) PROTECTED HEALTH INFORMATION.—The term 'protected health information' means any information, including demographic information collected from an individual, whether oral or recorded in any form or medium, that—

''(A) is created or received by a health care provider, health plan, health oversight agency, health researcher, public health authority, employer, life insurer, school or university, or certified health information network service; and

''(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and—

''(i) identifies an individual; or

''(ii) with respect to which there is a reasonable basis to believe that the information can be used to identify an individual.

''(2) DISCLOSE.—The term 'disclose', when used with respect to protected health information, means to provide access to the information, but only if such access is provided to a person other than the individual who is the subject of the information.

''(b) TERMS RELATING TO HEALTH CARE SYSTEM PARTICIPANTS.—In this subtitle:

''(1) HEALTH INFORMATION TRUSTEE.—The term 'health information trustee' means—

''(A) a health care provider, health plan, health oversight agency, certified health information network service, employer, life insurer, or school or university insofar as it creates, receives, maintains, uses, or transmits protected health information;

''(B) any person who obtains protected health information under section 11823, 11832, 11833, 11841, 11842, 11851, or 11854; and

''(C) any employee or agent of a person covered under subparagraphs (A) or (B).

''(2) HEALTH CARE.—The term 'health care'—

''(A) means—

''(i) a preventative, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, counseling, service, or procedure—

''(I) with respect to the physical or mental condition of an individual; or

''(II) affecting the structure or function of the human body or any part of the human body; or

''(ii) any sale or dispensing of a drug, device, equipment, or other item to an individual, or for the use of an individual, pursuant to a prescription; but

''(B) does not include any item or service that is not furnished for the purpose of examining, maintaining, or improving the health of an individual.

''(3) HEALTH CARE PROVIDER.—The term 'health care provider' means a person who is licensed, certified, registered, or otherwise authorized by law to provide an item or service that constitutes health care in the ordinary course of business or practice of a profession.

''(4) HEALTH OVERSIGHT AGENCY.—The term 'health oversight agency' means a person who—

''(A) performs or oversees the performance of an assessment, evaluation, determination, or investigation relating to the licensing, accreditation, or certification of health care providers; or

''(B)(i) performs or oversees the performance of an assessment, evaluation, determination, or investigation relating to the effectiveness of, compliance with, or applicability of legal, fiscal, medical, or scientific standards or aspects of performance related to the delivery of, or payment for, health care or relating to health care fraud or fraudulent claims for payment regarding health; and

''(ii) is a public agency, acting on behalf of a public agency, acting pursuant to a requirement of a public agency, or carrying out activities under a Federal or State law governing the assessment, evaluation, determination, or investigation described in clause (i).

''(5) HEALTH PLAN.—The term 'health plan' shall have the meaning given such term under section 11702.

''(6) HEALTH RESEARCHER.—The term 'health researcher' means a person who conducts a biomedical, public health, epidemiological, health services, or health statistics research project or a research project on social and behavioral factors relating to health.

''(7) INSTITUTIONAL REVIEW BOARD.—The term 'institutional review board' means—

''(A) a board established in accordance with regulations of the Secretary under section 491(a) of the Public Health Service Act;

''(B) a similar board established by the Secretary for the protection of human subjects in research conducted by the Secretary; or

''(C) a similar board established under regulations of a Federal Government authority other than the Secretary.

''(8) PUBLIC HEALTH AUTHORITY.—The term 'public health authority' means an authority or instrumentality of the United States, a State, or a political subdivision of a State that is (A) responsible for public health matters; and (B) engaged in such activities as injury reporting, public health surveillance, and public health investigation or intervention.

''(c) REFERENCES TO CERTIFIED ENTITIES.—In this subtitle:

''(1) CERTIFIED HEALTH INFORMATION NETWORK SERVICE.—The term 'certified health information network service' means a health information service (as defined under section 11702) that is certified under section 11741.

''(2) CERTIFIED HEALTH INFORMATION PROTECTION ORGANIZATION.—The term 'certified health information protection organization' means a health information protection organization (as defined in section 11702) that is certified under section 11741.

''(d) OTHER TERMS.—In this subtitle:

''(1) INDIVIDUAL REPRESENTATIVE.—The term 'individual representative' means any individual legally empowered to make decisions concerning the provision of health care to an individual (where the individual lacks the legal capacity under State law to make such decisions) or the administrator or executor of the estate of a deceased individual.

''(2) LAW ENFORCEMENT INQUIRY.—The term 'law enforcement inquiry' means an investigation or official proceeding inquiring into whether there is a violation of, or failure to comply with, any criminal

or civil statute or any regulation, rule, or order issued pursuant to such a statute.

''(3) PERSON.—The term 'person' includes an authority of the United States, a State, or a political subdivision of a State.

"PART II—AUTHORIZED DISCLOSURES

"Subpart A—General Provisions

"SEC. 11811. GENERAL RULES REGARDING DISCLOSURE.

''(a) GENERAL RULE.—A health information trustee may disclose protected health information only for a purpose that is authorized under this subtitle.

''(b) DISCLOSURE WITHIN A TRUSTEE.—A health information trustee may disclose protected health information to an officer, employee, or agent of the trustee, but only for a purpose that is compatible with and related to the purpose for which the information was collected or received by that trustee.

''(c) SCOPE OF DISCLOSURE.—

''(1) IN GENERAL.—Every disclosure of protected health information by a health information trustee shall be limited to the minimum amount of information necessary to accomplish the purpose for which the information is disclosed.

''(2) REGULATIONS.—The Secretary, after notice and opportunity for public comment, may issue

regulations under paragraph (1), which shall take into account the technical capabilities of the record systems used to maintain protected health information and the costs of limiting disclosure.

''(d) NO GENERAL REQUIREMENT TO DISCLOSE.—Nothing in this subtitle that permits a disclosure of health information shall be construed to require such disclosure.

''(e) USE AND REDISCLOSURE OF INFORMATION.—The protected health information received under a disclosure permitted by the subtitle may not be used or disclosed unless the use or disclosure is necessary to fulfill the purpose for which the information was obtained and is not otherwise prohibited by law. Protected health information about an individual that is disclosed under this subtitle may not be used in, or disclosed to any person for use in, any administrative, civil, or criminal action or investigation directed against the individual unless specifically permitted by this subtitle.

''(f) IDENTIFICATION OF DISCLOSED INFORMATION AS PROTECTED INFORMATION.—

''(1) IN GENERAL.—Except with respect to protected health information that is disclosed under section 11823 and except as provided in paragraph (2), a health information trustee may not disclose protected health information unless such information is

clearly identified as protected health information that is subject to this subtitle.

''(2) ROUTINE DISCLOSURES SUBJECT TO WRITTEN AGREEMENT.—A health information trustee who routinely discloses protected health information to a person may satisfy the identification requirement in paragraph (1) through a written agreement between the trustee and the person with respect to the protected health information.

''(g) CONSTRUCTION.—Nothing in this subtitle shall be construed to limit the ability of a health information trustee to charge a reasonable fee for the disclosure or reproduction of health information.

''(h) INFORMATION IN WHICH PROVIDERS ARE IDENTIFIED.—The Secretary, after notice and opportunity for public comment, may issue regulations protecting information identifying providers in order to promote the availability of health care services.

"SEC. 11812. AUTHORIZATIONS FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION.

''(a) WRITTEN AUTHORIZATIONS.—A health information trustee may disclose protected health information pursuant to an authorization executed by the individual who is the subject of the information, if each of the following requirements is met:

''(1) WRITING.—The authorization is in writing, signed by the individual who is the subject of the information, and dated on the date of such signature.

''(2) SEPARATE FORM.—The authorization is not on a form used to authorize or facilitate the provision of, or payment for, health care.

''(3) TRUSTEE DESCRIBED.—The trustee is specifically named or generically described in the authorization as authorized to disclose such information.

''(4) RECIPIENT DESCRIBED.—The person to whom the information is to be disclosed is specifically named or generically described in the authorization as a person to whom such information may be disclosed.

''(5) STATEMENT OF INTENDED DISCLOSURES.—The authorization contains an acknowledgment that the individual who is the subject of the information has read a statement of the disclosures that the person to receive the protected health information intends to make, which statement shall be in writing, on a form that is distinct from the authorization for disclosure, and which statement must be

received by the individual authorizing the disclosure on or before such authorization is executed.

''(6) INFORMATION DESCRIBED.—The information to be disclosed is described in the authorization.

''(7) EXPIRATION DATE SPECIFIED.—The authorization specifies a date or event upon which the authorization expires, which shall not exceed 2 years from the date of the execution of the authorization.

''(8) AUTHORIZATION TIMELY RECEIVED.—The authorization is received by the trustee during a period described in subsection (b)(1).

''(9) DISCLOSURE TIMELY MADE.—The disclosure occurs during a period described in subsection (b)(2).

''(b) TIME LIMITATIONS ON AUTHORIZATIONS.—

''(1) RECEIPT BY TRUSTEE.—For purposes of subsection (a)(8), an authorization is timely received if it is received by the trustee during—

''(A) the 1-year period beginning on the date on which the authorization is signed under subsection (a)(1), if the authorization permits the disclosure of protected health information to a person who provides health counseling or social services to individuals; or

''(B) the 30-day period beginning on the date on which the authorization is signed under subsection (a)(1), if the authorization permits the disclosure of protected health information to a person other than a person described in subparagraph (A).

''(2) DISCLOSURE BY TRUSTEE.—For purposes of subsection (a)(9), a disclosure is timely made if it occurs before the date or event specified in the authorization upon which the authorization expires.

''(c) REVOCATION OR AMENDMENT OF AUTHORIZATION.—

''(1) IN GENERAL.—An individual may in writing revoke or amend an authorization described in subsection (a), in whole or in part, at any time, except when—

''(A) disclosure of protected health information has been authorized to permit validation of expenditures for health care; or

''(B) action has been taken in reliance on the authorization.

''(2) NOTICE OF REVOCATION.—A health information trustee who discloses protected health information pursuant to an authorization that has been

revoked shall not be subject to any liability or penalty under this subtitle if—

''(A) the reliance was in good faith;

''(B) the trustee had no notice of the revocation; and

''(C) the disclosure was otherwise in accordance with the requirements of this subtitle.

''(d) DECEASED INDIVIDUAL.—The Secretary shall develop and establish through regulation a procedure for obtaining protected health information relating to a deceased individual when there is no individual representative for such individual.

''(e) MODEL AUTHORIZATIONS.—The Secretary, after notice and opportunity for public comment, shall develop and disseminate model written authorizations of the type described in subsection (a) and model statements of intended disclosures of the type described in subsection (a)(5).

''(f) COPY.—A health information trustee who discloses protected health information pursuant to an authorization under this section shall maintain a copy of the authorization.

"SEC. 11813. CERTIFIED HEALTH INFORMATION NETWORK SERVICES.

''(a) IN GENERAL.—A health information trustee may disclose protected health information to a certified health information network service acting as an agent of the trustee for any purpose permitted by this subtitle. Such a service, acting as an agent of a trustee, may disclose protected health information to another person as permitted under this subtitle to facilitate the completion of the purpose for which such information was disclosed to the service.

''(b) CERTIFIED HEALTH INFORMATION PROTECTION ORGANIZATIONS.—A health information trustee may disclose protected health information to a certified health information protection organization for the purpose of creating non-identifiable health information (as defined in section 11702).

"Subpart B—Specific Disclosures Relating to Patient

"SEC. 11821. DISCLOSURES FOR TREATMENT AND FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.

''(a) HEALTH CARE TREATMENT.—A health care provider, health plan, employer, or person who receives protected health information under section 11823, may disclose protected health information to a health care provider for the purpose of providing health care to an individual if the individual who is the subject of the informa-

tion has not previously objected in writing to the disclosure.

''(b) DISCLOSURE TO HEALTH PLANS FOR FINANCIAL AND ADMINISTRATIVE PURPOSES.—A health care provider or employer may disclose protected health information to a health plan for the purpose of providing for the payment for, or reviewing the payment of, health care furnished to an individual.

''(c) DISCLOSURE BY HEALTH PLANS FOR FINANCIAL AND ADMINISTRATIVE PURPOSES.—A health plan may disclose protected health information to a health care provider or a health plan for the purpose of providing for the payment for, or reviewing the payment of, health care furnished to an individual.

"SEC. 11822. NEXT OF KIN AND DIRECTORY INFORMATION.

''(a) NEXT OF KIN.—A health care provider or person who receives protected health information under section 11823 may disclose protected health information to the next of kin, an individual representative of the individual who is the subject of the information, or an individual with whom that individual has a close personal relationship if—

''(1) the individual who is the subject of the information—

''(A) has been notified of the individual's right to object and has not objected to the disclosure;

''(B) is not competent to be notified about the right to object; or

''(C) exigent circumstances exist such that it would not be practicable to notify the individual of the right to object; and

''(2) the information disclosed relates to health care currently being provided to that individual.

''(b) DIRECTORY INFORMATION.—A health care provider and a person receiving protected health information under section 11823 may disclose protected health information to any person if—

''(1) the information does not reveal specific information about the physical or mental condition of the individual who is the subject of the information or health care provided to that person;

''(2) the individual who is the subject of the information—

''(A) has been notified of the individual's right to object and has not objected to the disclosure;

''(B) is not competent to be notified about the right to object; or

''(C) exigent circumstances exist such that it would not be practicable to notify the individual of the right to object; and

''(3) the information consists only of 1 or more of the following items:

''(A) The name of the individual who is the subject of the information.

''(B) If the individual who is the subject of the information is receiving health care from a health care provider on a premises controlled by the provider—

''(i) the location of the individual on the premises; and

''(ii) the general health status of the individual, described as critical, poor, fair, stable, or satisfactory or in terms denoting similar conditions.

''(d) IDENTIFICATION OF DECEASED INDIVIDUAL.—A health care provider, health plan, employer, or life insurer, may disclose protected health information if necessary to assist in the identification of a deceased individual.

''SEC. 11823. EMERGENCY CIRCUMSTANCES.

''(a) IN GENERAL.—A health care provider, health plan, employer, or person who receives protected health

information under this section may disclose protected health information in emergency circumstances when necessary to protect the health or safety of an individual from imminent harm.

''(b) SCOPE OF DISCLOSURE.—The disclosure of protected health information under this section shall be limited to persons who need the information to take action to protect the health or safety of the individual.

"Subpart C—Disclosure for Oversight, Public Health, and Research Purposes

"SEC. 11831. OVERSIGHT.

''(a) IN GENERAL.—A health information trustee may disclose protected health information to a health oversight agency for an oversight function authorized by law.

''(b) USE IN ACTION AGAINST INDIVIDUALS.—Notwithstanding section 11811(e), protected health information about an individual that is disclosed under this section may be used in, or disclosed to any person for use in, any administrative, civil, or criminal action or investigation directed against the individual who is the subject of the information if the action or investigation arises out of and is directly related to receipt of health care or payment for health care or an action involving a fraudulent claim related to health.

''SEC. 11832. PUBLIC HEALTH.

''A health care provider, health plan, public health authority, employer, or person who receives protected health information under section 11823 may disclose protected health information to a public health authority or other person authorized by law for use in a legally authorized—

''(1) disease or injury reporting;

''(2) public health surveillance; or

''(3) public health investigation or intervention.

''SEC. 11833. HEALTH RESEARCH.

''(a) IN GENERAL.—A health information trustee may disclose protected health information to a health researcher if an institutional review board determines that the research project engaged in by the health researcher—

''(1) requires use of the protected health information for the effectiveness of the project; and

''(2) is of sufficient importance to outweigh the intrusion into the privacy of the individual who is the subject of the information that would result from the disclosure.

''(b) RESEARCH REQUIRING DIRECT CONTACT.—A health information trustee may disclose protected health information to a health researcher for a research project that includes direct contact with an individual who is the

subject of protected health information if an institutional review board determines that—

''(1) the research project meets the requirements of paragraphs (1) and (2) of subsection (a);

''(2) direct contact is necessary to accomplish the research purpose; and

''(3) the direct contact will be made in a manner that minimizes the risk of harm, embarrassment, or other adverse consequences to the individual.

''(c) USE OF HEALTH INFORMATION NETWORK.—

''(1) IN GENERAL.—A health information trustee may disclose protected health information to a health researcher using the health information network (as defined in section 11702) only if an institutional review board certified by the Secretary under paragraph (2) determines that the research project engaged in by the health researcher meets the requirements of this section.

''(2) CERTIFICATION OF INSTITUTIONAL REVIEW BOARDS.—

''(A) REGULATIONS.—The Secretary, after notice and opportunity for public comment, shall issue regulations establishing certification requirements for institutional review boards under this subtitle. Such regulations shall be

based on regulations issued under section 491(a) of the Public Health Service Act and shall ensure that institutional review boards certified under this paragraph have the qualifications to access and protect the confidentiality of research subjects.

''(B) CERTIFICATION.—The Secretary shall certify an institutional review board that meets the certification requirements established by the Secretary under subparagraph (A).

''(d) OBLIGATIONS OF RECIPIENT.—A person who receives protected health information pursuant to subsection (a)—

''(1) shall remove or destroy, at the earliest opportunity consistent with the purposes of the project, information that would enable an individual to be identified, unless—

''(A) an institutional review board has determined that there is a health or research justification for retention of such identifiers; and

''(B) there is an adequate plan to protect the identifiers from disclosure that is inconsistent with this section; and

''(2) shall use protected health information solely for purposes of the health research project for which disclosure was authorized under this section.

"Subpart D—Disclosure For Judicial, Administrative, and Law Enforcement Purposes

"SEC. 11841. JUDICIAL AND ADMINISTRATIVE PURPOSES.

A health care provider, health plan, health oversight agency, or employer may disclose protected health information—

''(1) pursuant to the Federal Rules of Civil Procedure, the Federal Rules of Criminal Procedure, or comparable rules of other courts or administrative agencies in connection with litigation or proceedings to which the individual who is the subject of the information is a party and in which the individual has placed the individual's physical or mental condition in issue;

''(2) to a court, and to others ordered by a court, if the protected health information is developed in response to a court-ordered physical or mental examination; or

''(3) pursuant to a law requiring the reporting of specific medical information to law enforcement authorities.

"SEC. 11842. LAW ENFORCEMENT.

''(a) IN GENERAL.—A health care provider, health plan, health oversight agency, employer, or person who receives protected health information under section 11823 may disclose protected health information to a law enforcement agency (other than a health oversight agency governed by section 11831) if the information is requested for use—

''(1) in an investigation or prosecution of a health information trustee;

''(2) in the identification of a victim or witness in a law enforcement inquiry; or

''(3) in connection with the investigation of criminal activity committed against the trustee or on premises controlled by the trustee.

''(b) CERTIFICATION.—When a law enforcement agency (other than a health oversight agency) requests that a health information trustee disclose protected health information under this section, the law enforcement agency shall provide the trustee with a written certification that—

''(1) specifies the information requested;

''(2) states that the information is needed for a lawful purpose under this section; and

''(3) is signed by a supervisory official of a rank designated by the head of the agency.

''(c) RESTRICTIONS ON ADDITIONAL DISCLOSURE.—Notwithstanding section 11811(e), protected health information about an individual that is disclosed to a law enforcement agency under this section may be used in, or disclosed for, an administrative, civil, or criminal action or investigation against the individual if the action or investigation arises out of and is directly related to the action or investigation for which the information was obtained.

"Subpart E—Disclosure Pursuant to Government Subpoena or Warrant

"SEC. 11851. GOVERNMENT SUBPOENAS AND WARRANTS.

''(a) IN GENERAL.—A health care provider, health plan, health oversight agency, employer, or person who receives protected health information under section 11823 may disclose protected health information under this section if the disclosure is pursuant to—

''(1) a subpoena issued under the authority of a grand jury, and the trustee is provided a written certification by the grand jury seeking the information that the grand jury has complied with the applicable access provisions of section 11852;

''(2) an administrative subpoena or a judicial subpoena or warrant, and the trustee is provided a written certification by the person seeking the infor-

mation that the person has complied with the applicable access provisions of section 11852; or

''(3) an administrative subpoena or a judicial subpoena or warrant, and the disclosure otherwise meets the conditions of section 11831, 11832, 11841, or 11842.

''(b) RESTRICTIONS ON ADDITIONAL DISCLOSURE.—

''(1) ACTIONS OR INVESTIGATIONS.—Notwithstanding section 11811(c), protected health information about an individual that is received under subsection (a) may be disclosed for, or used in, any administrative, civil, or criminal action or investigation against the individual if the action or investigation arises out of and is directly related to the inquiry for which the information was obtained.

''(2) SPECIAL RULE.—Protected health information about an individual that is received under subsection (a)(3) may not be disclosed by the recipient unless the recipient complies with the conditions and restrictions on disclosure with which the recipient would have been required to comply if the disclosure had been made under section 11831, 11832, 11841, or 11842.

"SEC. 11852. ACCESS PROCEDURES FOR LAW ENFORCEMENT SUBPOENAS AND WARRANTS.

''(a) PROBABLE CAUSE REQUIREMENT.—A government authority may not obtain protected health information about an individual under paragraph (1) or (2) of section 11851(a) for use in a law enforcement inquiry unless there is probable cause to believe that the information is relevant to a legitimate law enforcement inquiry being conducted by the government authority.

''(b) WARRANTS.—A government authority that obtains protected health information about an individual under circumstances described in subsection (a) and pursuant to a warrant shall, not later than 30 days after the date the warrant was executed, serve the individual with, or mail to the last known address of the individual, a notice that protected health information about the individual was so obtained, together with a notice of the individual's right to challenge the warrant in accordance with section 11853.

''(c) SUBPOENAS.—Except as provided in subsection (d), a government authority may not obtain protected health information about an individual under circumstances described in subsection (a) and pursuant to a subpoena unless a copy of the subpoena has been served on the individual on or before the date of return of the subpoena, together with a notice of the individual's right

to challenge the subpoena in accordance with section 11853, and—

''(1) 30 days have passed since the date of service on the individual and within that time period the individual has not initiated a challenge in accordance with section 11853; or

''(2) disclosure is ordered by a court after challenge under section 11853.

''(d) APPLICATION FOR DELAY.—

''(1) IN GENERAL.—A government authority may apply ex parte and under seal to an appropriate court to delay (for an initial period of not longer than 90 days) serving a notice or copy of a subpoena required under subsection (b) or (c) with respect to a law enforcement inquiry. The government authority may apply to the court for extensions of the delay.

''(2) REASONS FOR DELAY.—An application for a delay, or extension of a delay, under this subsection shall state, with reasonable specificity, the reasons why the delay or extension is being sought.

''(3) EX PARTE ORDER.—The court shall enter an ex parte order delaying or extending the delay of notice, an order prohibiting the disclosure of the request for, or disclosure of, the protected health in-

formation, and an order requiring the disclosure of the protected health information if the court finds that—

''(A) the inquiry being conducted is within the lawful jurisdiction of the government authority seeking the protected health information;

''(B) there is probable cause to believe that the protected health information being sought is relevant to a legitimate law enforcement inquiry;

''(C) the government authority's need for the information outweighs the privacy interest of the individual who is the subject of the information; and

''(D) there is reasonable ground to believe that receipt of notice by the individual will result in—

''(i) endangering the life or physical safety of any individual;

''(ii) flight from prosecution;

''(iii) destruction of or tampering with evidence or the information being sought; or

''(iv) intimidation of potential witnesses.

"SEC. 11853. CHALLENGE PROCEDURES FOR LAW ENFORCEMENT WARRANTS AND SUBPOENAS.

''(a) MOTION TO QUASH.—Within 30 days after the date of service of a notice of execution or a copy of a subpoena of a government authority seeking protected health information about an individual under paragraph (1) or (2) of section 11851(a), the individual may file a motion to quash—

''(1) in the case of a State judicial warrant or subpoena, in the court which issued the warrant or subpoena;

''(2) in the case of a warrant or subpoena issued under the authority of a State that is not a State judicial warrant or subpoena, in a court of competent jurisdiction; or

''(3) in the case of any other warrant or subpoena issued under the authority of a Federal court or the United States, in the United States district court for the district in which the individual resides or in which the warrant or subpoena was issued.

''(b) COPY.—A copy of the motion shall be served by the individual upon the government authority by registered or certified mail.

''(c) PROCEEDINGS.—The government authority may file with the court such papers, including affidavits and other sworn documents, as sustain the validity of the warrant or subpoena. The individual may file with the court reply papers in response to the government authority's filing. The court, upon the request of the individual or the government authority or both, may proceed in camera. The court may conduct such proceedings as it deems appropriate to rule on the motion, but shall endeavor to expedite its determination.

''(d) STANDARD FOR DECISION.—A court may deny a motion under subsection (a) if it finds there is probable cause to believe the protected health information is relevant to a legitimate law enforcement inquiry being conducted by the government authority, unless the court finds the individual's privacy interest outweighs the government authority's need for the information. The individual shall have the burden of demonstrating that the individual's privacy interest outweighs the need by the government authority for the information.

''(e) SPECIFIC CONSIDERATIONS WITH RESPECT TO PRIVACY INTEREST.—In reaching its determination, the court shall consider—

''(1) the particular purpose for which the information was collected;

''(2) the degree to which disclosure of the information will embarrass, injure, or invade the privacy of the individual;

''(3) the effect of the disclosure on the individual's future health care;

''(4) the importance of the inquiry being conducted by the government authority, and the importance of the information to that inquiry; and

''(5) any other factor deemed relevant by the court.

''(f) ATTORNEY'S FEES.—In the case of a motion brought under subsection (a) in which the individual has substantially prevailed, the court may assess against the government authority a reasonable attorney's fee and other litigation costs (including expert's fees) reasonably incurred.

''(g) NO INTERLOCUTORY APPEAL.—A ruling denying a motion to quash under this section shall not be deemed to be a final order, and no interlocutory appeal may be taken therefrom by the individual. An appeal of such a ruling may be taken by the individual within such period of time as is provided by law as part of any appeal from a final order in any legal proceeding initiated against the individual arising out of or based upon the protected health information disclosed.

''Subpart F—Disclosure Pursuant to Private Party Subpoena

''SEC. 11854. PRIVATE PARTY SUBPOENAS.

''A health care provider, health plan, employer, or person who receives protected health information under section 11823 may disclose protected health information under this section if the disclosure is pursuant to a subpoena issued on behalf of a private party who has complied with the access provisions of section 11855.

''SEC. 11855. ACCESS PROCEDURES FOR PRIVATE PARTY SUBPOENAS.

''A private party may not obtain protected health information about an individual pursuant to a subpoena unless a copy of the subpoena together with a notice of the individual's right to challenge the subpoena in accordance with section 11856 has been served upon the individual on or before the date of return of the subpoena, and—

''(1) 30 days have passed since the date of service on the individual, and within that time period the individual has not initiated a challenge in accordance with section 11856; or

''(2) disclosure is ordered by a court under section 11856.

"SEC. 11856. CHALLENGE PROCEDURES FOR PRIVATE PARTY SUBPOENAS.

''(a) MOTION TO QUASH SUBPOENA.—Within 30 days after service of a copy of the subpoena seeking protected health information under section 11854, the individual who is the subject of the protected health information may file in any court of competent jurisdiction a motion to quash the subpoena and serve a copy of the motion on the person seeking the information.

''(b) STANDARD FOR DECISION.—The court shall grant a motion under subsection (a) unless the respondent demonstrates that—

''(1) there is reasonable ground to believe the information is relevant to a lawsuit or other judicial or administrative proceeding; and

''(2) the need of the respondent for the information outweighs the privacy interest of the individual.

''(c) SPECIFIC CONSIDERATIONS WITH RESPECT TO PRIVACY INTEREST.—In determining under subsection (b) whether the need of the respondent for the information outweighs the privacy interest of the individual, the court shall consider—

''(1) the particular purpose for which the information was collected;

''(2) the degree to which disclosure of the information would embarrass, injure, or invade the privacy of the individual;

''(3) the effect of the disclosure on the individual's future health care;

''(4) the importance of the information to the lawsuit or proceeding; and

''(5) any other relevant factor.

''(d) ATTORNEY'S FEES.—In the case of a motion brought under subsection (a) in which the individual has substantially prevailed, the court may assess against the respondent a reasonable attorney's fee and other litigation costs and expenses (including expert's fees) reasonably incurred.

"PART III—PROCEDURES FOR ENSURING SECURITY OF PROTECTED HEALTH INFORMATION

"Subpart A—Establishment of Safeguards

"SEC. 11861. ESTABLISHMENT OF SAFEGUARDS.

''(a) IN GENERAL.—A health information trustee shall establish and maintain appropriate administrative, technical, and physical safeguards—

''(1) to ensure the integrity and confidentiality of protected health information created or received by the trustee; and

''(2) to protect against any anticipated threats or hazards to the security or integrity of such information.

''(b) REGULATIONS.—The Secretary shall promulgate regulations regarding security measures for protected health information. In developing such regulations, the Secretary shall consult with appropriate private parties with expertise in safeguarding health information.

"SEC. 11862. ACCOUNTING FOR DISCLOSURES.

''(a) IN GENERAL.—

''(1) REQUIREMENT TO CREATE OR MAINTAIN RECORD.—A health information trustee shall create and maintain, with respect to any protected health information disclosed in exceptional circumstances (as described in paragraph (2)), a record of—

''(A) the date and purpose of the disclosure;

''(B) the name of the person to whom or to which the disclosure was made;

''(C) the address of the person to whom or to which the disclosure was made or the location to which the disclosure was made; and

''(D) the information disclosed, if the recording of the information disclosed is practicable, taking into account the technical capa-

bilities of the system used to maintain the record and the costs of such maintenance.

''(2) EXCEPTIONAL CIRCUMSTANCES DESCRIBED.—For purposes of paragraph (1) protected health information is disclosed in exceptional circumstances if the disclosure—

''(A) is not a routine part of doing business, as determined in accordance with guidelines promulgated by the Secretary; or

''(B) is permitted under sections 11823 and 11832.

''(b) DISCLOSURE RECORD PART OF INFORMATION.—A record created and maintained under paragraph (a) shall be maintained as part of the protected health information to which the record pertains.

"Subpart B—Review of Protected Health Information By Subjects of the Information

"SEC. 11871. INSPECTION OF PROTECTED HEALTH INFORMATION.

''(a) IN GENERAL.—Except as provided in subsection (c), a health care provider or health plan—

''(1) shall permit an individual who is the subject of protected health information to inspect any such information that the provider or plan maintains;

''(2) shall permit the individual to have a copy of the information;

''(3) shall permit a person who has been designated in writing by the individual who is the subject of the information to inspect the information on behalf of the individual or to accompany the individual during the inspection; and

''(4) may offer to explain or interpret information that is inspected or copied under this subsection.

''(b) ADDITIONAL REQUESTS.—Except as provided in subsection (c), a health plan or health care provider shall, upon written request of an individual—

''(1) determine the identity of previous providers to the individual; and

''(2) obtain protected health information regarding the individual.

''(c) EXCEPTIONS.—A health care provider or health plan is not required by this section to permit inspection or copying of protected health information if any of the following conditions apply:

''(1) MENTAL HEALTH TREATMENT NOTES.—The information consists of psychiatric, psychological, or mental health treatment notes, and the provider or plan determines, based on reasonable

medical judgment, that inspection or copying of the notes would cause sufficient harm to the individual who is the subject of the notes so as to outweigh the desirability of permitting access, and the provider or plan has not disclosed the notes to any person not directly engaged in treating the individual, except with the authorization of the individual or under compulsion of law.

''(2) INFORMATION ABOUT OTHERS.—The information relates to an individual other than the individual seeking to inspect or have a copy of the information and the provider or plan determines, based on reasonable medical judgment, that inspection or copying of the information would cause sufficient harm to 1 or both of the individuals so as to outweigh the desirability of permitting access.

''(3) ENDANGERMENT TO LIFE OR SAFETY.—The provider or plan determines that disclosure of the information could reasonably be expected to endanger the life or physical safety of any individual.

''(4) CONFIDENTIAL SOURCE.—The information identifies or could reasonably lead to the identification of a person (other than a health care provider) who provided information under a promise of con-

fidentiality to a health care provider concerning the individual who is the subject of the information.

''(5) ADMINISTRATIVE PURPOSES.—The information—

''(A) is used by the provider or plan solely for administrative purposes and not in the provision of health care to the individual who is the subject of the information; and

''(B) has not been disclosed by the provider or plan to any other person.

''(d) INSPECTION AND COPYING OF SEGREGABLE PORTION.—A health care provider or health plan shall permit inspection and copying under subsection (a) of any reasonably segregable portion of a record after deletion of any portion that is exempt under subsection (c).

''(e) CONDITIONS.—A health care provider or health plan may require a written request for the inspection and copying of protected health information under this subsection. The health care provider or health plan may require a reasonable cost reimbursement for such inspection and copying.

''(f) STATEMENT OF REASONS FOR DENIAL.—If a health care provider or health plan denies a request for inspection or copying under this section, the provider or plan shall provide the individual who made the request (or

the individual's designated representative) with a written statement of the reasons for the denial.

''(g) DEADLINE.—A health care provider or health plan shall comply with or deny a request for inspection or copying of protected health information under this section within the 30-day period beginning on the date on which the provider or plan receives the request.

"SEC. 11872. AMENDMENT OF PROTECTED HEALTH INFORMATION.

''(a) IN GENERAL.—A health care provider or health plan shall, within the 45-day period beginning on the date on which the provider or plan receives from an individual a written request that the provider or plan correct or amend the information—

''(1) make the correction or amendment requested;

''(2) inform the individual of the correction or amendment that has been made; and

''(3) inform any person who is identified by the individual, who is not an officer, employee or agent of the provider or plan, and to whom the uncorrected or unamended portion of the information was previously disclosed, of the correction or amendment that has been made.

''(b) REFUSAL TO CORRECT.—If the provider or plan refuses to make the corrections, the provider or plan shall inform the individual of—

''(1) the reasons for the refusal of the provider or plan to make the correction or amendment;

''(2) any procedures for further review of the refusal; and

''(3) the individual's right to file with the provider or plan a concise statement setting forth the requested correction or amendment and the individual's reasons for disagreeing with the refusal of the provider or plan.

''(c) BASES FOR REQUEST TO CORRECT OR AMEND.—An individual may request correction or amendment of protected health information about the individual under paragraph (a) if the information is not timely, accurate, relevant to the system of records, or complete.

''(d) STATEMENT OF DISAGREEMENT.—After an individual has filed a statement of disagreement under paragraph (b)(3), the provider or plan, in any subsequent disclosure of the disputed portion of the information—

''(1) shall include a copy of the individual's statement; and

''(2) may include a concise statement of the reasons of the provider or plan for not making the requested correction or amendment.

''(e) RULE OF CONSTRUCTION.—This section shall not be construed to require a health care provider or health plan to conduct a formal, informal, or other hearing or proceeding concerning a request for a correction or amendment to protected health information the provider or plan maintains.

''(f) CORRECTION.—For purposes of paragraph (a), a correction is deemed to have been made to protected health information when information that is not timely, accurate, relevant to the system of records, or complete is clearly marked as incorrect or when supplementary correct information is made part of the information.

"SEC. 11873. NOTICE OF INFORMATION PRACTICES.

''(a) PREPARATION OF WRITTEN NOTICE.—A health care provider or health plan shall prepare a written notice of information practices describing the following:

''(1) PERSONAL RIGHTS OF AN INDIVIDUAL.—The rights under this subpart of an individual who is the subject of protected health information, including the right to inspect and copy such information and the right to seek amendments to such information, and the procedures for authorizing disclo-

sures of protected health information and for revoking such authorizations.

''(2) PROCEDURES OF PROVIDER OR PLAN.—The procedures established by the provider or plan for the exercise of the rights of individuals about whom protected health information is maintained.

''(3) AUTHORIZED DISCLOSURES.—The disclosures of protected health information that are authorized.

''(b) DISSEMINATION OF NOTICE.—A health care provider or health plan—

''(1) shall, upon request, provide any individual with a copy of the notice of information practices described in subsection (a); and

''(2) shall make reasonable efforts to inform individuals in a clear and conspicuous manner of the existence and availability of the notice.

''(c) MODEL NOTICE.—The Secretary, after notice and opportunity for public comment, shall develop and disseminate a model notice of information practices for use by health care providers and health plans under this section.

''Subpart C—Standards for Electronic Disclosures

''SEC. 11882. STANDARDS FOR ELECTRONIC DISCLOSURES.

''The Secretary shall promulgate standards for disclosing protected health information in accordance with this subtitle in electronic form. Such standards shall include standards relating to the creation, transmission, receipt, and maintenance, of any written document required or authorized under this subtitle.

''PART IV—SANCTIONS

''Subpart A—No Sanctions for Permissible Actions

''SEC. 11891. NO LIABILITY FOR PERMISSIBLE DISCLOSURES.

''A health information trustee who makes a disclosure of protected health information about an individual that is permitted by this subtitle shall not be liable to the individual for the disclosure under common law.

''SEC. 11892. NO LIABILITY FOR INSTITUTIONAL REVIEW BOARD DETERMINATIONS.

''If the members of an institutional review board make a determination in good faith that—

''(1) a health research project is of sufficient importance to outweigh the intrusion into the privacy of an individual; and

''(2) the effectiveness of the project requires use of protected health information,

the members, the board, and the parent institution of the board shall not be liable to the individual as a result of the determination.

''SEC. 11893. RELIANCE ON CERTIFIED ENTITY.

''If a health information trustee contracts with a certified health information network service to make a disclosure of any protected health information on behalf of such trustee in accordance with this subtitle and such service makes a disclosure of such information that is in violation of this subtitle, the trustee shall not be liable for to the individual who is the subject of the information for such unlawful disclosure.

''Subpart B—Civil Sanctions

''SEC. 11901. CIVIL PENALTY.

''(a) VIOLATION.—Any health information trustee who the Secretary determines has substantially failed to comply with this subtitle shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $10,000 for each such violation.

''(b) PROCEDURES FOR IMPOSITION OF PENALTIES.—Section 1128A, other than subsections (a) and (b) and the second sentence of subsection (f) of that section, shall apply to the imposition of a civil monetary penalty under this section in the same manner as such provi-

sions apply with respect to the imposition of a penalty under section 1128A.

"SEC. 11902. CIVIL ACTION.

''(a) IN GENERAL.—An individual who is aggrieved by conduct in violation of this subtitle may bring a civil action to recover—

''(1) the greater of actual damages or liquidated damages of $5,000;

''(2) punitive damages;

''(3) a reasonable attorney's fee and expenses of litigation;

''(4) costs of litigation; and

''(5) such preliminary and equitable relief as the court determines to be appropriate.

''(b) LIMITATION.—No action may be commenced under this section more than 3 years after the date on which the violation was or should reasonably have been discovered.

"Subpart C—Criminal Sanctions

"SEC. 11911. WRONGFUL DISCLOSURE OF PROTECTED HEALTH INFORMATION.

''(a) OFFENSE.—A person who knowingly—

''(1) obtains protected health information relating to an individual in violation of this subtitle; or

''(2) discloses protected health information to another person in violation of this subtitle,

shall be punished as provided in subsection (b).

''(b) PENALTIES.—A person described in subsection (a) shall—

''(1) be fined not more than $50,000, imprisoned not more than 1 year, or both;

''(2) if the offense is committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both; and

''(3) if the offense is committed with intent to sell, transfer, or use protected health information for commercial advantage, personal gain, or malicious harm, fined not more than $250,000, imprisoned not more than 10 years, or both.

''PART V—ADMINISTRATIVE PROVISIONS

''SEC. 11921. RELATIONSHIP TO OTHER LAWS.

''(a) STATE LAW.—Except as provided in subsections (b), (c), and (d), this subtitle preempts State law.

''(b) LAWS RELATING TO PUBLIC OR MENTAL HEALTH.—Nothing in this subtitle shall be construed to preempt or operate to the exclusion of any State law relating to public health or mental health that prevents or regulates disclosure of protected health information otherwise allowed under this subtitle.

''(c) PRIVILEGES.—Nothing in this subtitle is intended to preempt or modify State common or statutory law to the extent such law concerns a privilege of a witness or person in a court of the State. This subtitle does not supersede or modify Federal common or statutory law to the extent such law concerns a privilege of a witness or person in a court of the United States. Authorizations pursuant to section 11812 shall not be construed as a waiver of any such privilege.

''(d) CERTAIN DUTIES UNDER STATE OR FEDERAL LAW.—This subtitle shall not be construed to preempt, supersede, or modify the operation of—

''(1) any law that provides for the reporting of vital statistics such as birth or death information;

''(2) any law requiring the reporting of abuse or neglect information about any individual;

''(3) subpart II of part E of title XXVI of the Public Health Service Act (relating to notifications of emergency response employees of possible exposure to infectious diseases); or

''(4) any Federal law or regulation governing confidentiality of alcohol and drug patient records.

''SEC. 11922. RIGHTS OF INCOMPETENTS.

''(a) EFFECT OF DECLARATION OF INCOMPETENCE.—Except as provided in section 11923, if an in-

dividual has been declared to be incompetent by a court of competent jurisdiction, the rights of the individual under this subtitle shall be exercised and discharged in the best interests of the individual through the individual's representative.

''(b) NO COURT DECLARATION.—Except as provided in section 11923, if a health care provider determines that an individual, who has not been declared to be incompetent by a court of competent jurisdiction, suffers from a medical condition that prevents the individual from acting knowingly or effectively on the individual's own behalf, the right of the individual to authorize disclosure may be exercised and discharged in the best interest of the individual by the individual's representative.

"**SEC. 11923. EXERCISE OF RIGHTS.**

''(a) INDIVIDUALS WHO ARE 18 OR LEGALLY CAPABLE.—In the case of an individual—

''(1) who is 18 years of age or older, all rights of the individual shall be exercised by the individual; or

''(2) who, acting alone, has the legal right, as determined by State law, to apply for and obtain a type of medical examination, care, or treatment and who has sought such examination, care, or treatment, the individual shall exercise all rights of an in-

dividual under this subtitle with respect to protected health information relating to such examination, care, or treatment.

''(b) INDIVIDUALS UNDER 18.—Except as provided in subsection (a)(2), in the case of an individual who is—

''(1) under 14 years of age, all the individual's rights under this subtitle shall be exercised through the parent or legal guardian of the individual; or

''(2) 14, 15, 16, or 17 years of age, the rights of inspection and amendment, and the right to authorize disclosure of protected health information of the individual may be exercised either by the individual or by the parent or legal guardian of the individual.''.

(b) CONFORMING AMENDMENT.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 601, is amended by striking the title and inserting the following:

"TITLE XI—GENERAL PROVISIONS, PEER REVIEW, ADMINISTRATIVE SIMPLIFICATION, AND PRIVACY".

TITLE VII—ENHANCED PENALTIES FOR HEALTH CARE FRAUD

Subtitle A—All-Payer Fraud and Abuse Control Program

SEC. 701. ALL-PAYER FRAUD AND ABUSE CONTROL PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—

(1) IN GENERAL.—Not later than January 1, 1995, the Secretary of Health and Human Services (in this title referred to as the ''Secretary''), acting through the Office of the Inspector General of the Department of Health and Human Services, and the Attorney General shall establish a program—

(A) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to the delivery of and payment for health care in the United States,

(B) to conduct investigations, audits, evaluations, and inspections relating to the delivery

of and payment for health care in the United States,

(C) to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B of the Social Security Act and other statutes applicable to health care fraud and abuse, and

(D) to provide for the modification and establishment of safe harbors and to issue interpretative rulings and special fraud alerts pursuant to section 703.

(2) COORDINATION WITH HEALTH CARE PLANS.—In carrying out the program established under paragraph (1), the Secretary and the Attorney General shall consult with, and arrange for the sharing of data with representatives of health care plans.

(3) REGULATIONS.—

(A) IN GENERAL.—The Secretary and the Attorney General shall by regulation establish standards to carry out the program under paragraph (1).

(B) INFORMATION STANDARDS.—

(i) IN GENERAL.—Such standards shall include standards relating to the furnishing of information by health care plans, providers, and others to enable the

Secretary and the Attorney General to carry out the program (including coordination with health care plans under paragraph (2)).

(ii) CONFIDENTIALITY.—Such standards shall include procedures to assure that such information is provided and utilized in a manner that appropriately protects the confidentiality of the information and the privacy of individuals receiving health care services and items.

(iii) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) of the Social Security Act (relating to limitation on liability) shall apply to a person providing information to the Secretary or the Attorney General in conjunction with their performance of duties under this section, in the same manner as such section applies to information provided to organizations with a contract under part B of title XI of such Act, with respect to the performance of such a contract.

(C) DISCLOSURE OF OWNERSHIP INFORMATION.—

(i) IN GENERAL.—Such standards shall include standards relating to the disclosure of ownership information described in clause (ii) by any entity providing health care services and items.

(ii) OWNERSHIP INFORMATION DESCRIBED.—The ownership information described in this clause includes—

(I) a description of such items and services provided by such entity;

(II) the names and unique physician identification numbers of all physicians with a financial relationship (as defined in section 1877(a)(2) of the Social Security Act) with such entity;

(III) the names of all other individuals with such an ownership or investment interest in such entity; and

(IV) any other ownership and related information required to be disclosed by such entity under section

1124 or section 1124A of the Social Security Act.

(4) AUTHORIZATION OF APPROPRIATIONS FOR INVESTIGATORS AND OTHER PERSONNEL.—In addition to any other amounts authorized to be appropriated to the Secretary and the Attorney General for health care anti-fraud and abuse activities for a fiscal year, there are authorized to be appropriated additional amounts as may be necessary to enable the Secretary and the Attorney General to conduct investigations and audits of allegations of health care fraud and abuse and otherwise carry out the program established under paragraph (1) in a fiscal year.

(5) ENSURING ACCESS TO DOCUMENTATION.—The Inspector General of the Department of Health and Human Services is authorized to exercise the authority described in paragraphs (4) and (5) of section 6 of the Inspector General Act of 1978 (relating to subpoenas and administration of oaths) with respect to the activities under the all-payer fraud and abuse control program established under this subsection to the same extent as such Inspector General may exercise such authorities to perform the functions assigned by such Act.

(6) HEALTH CARE PLAN DEFINED.—For the purposes of this subsection, the term ''health care plan'' shall have the meaning given such term in section 1128(i) of the Social Security Act.

(b) ESTABLISHMENT OF ANTI-FRAUD AND ABUSE TRUST FUND.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the ''Anti-Fraud and Abuse Trust Fund'' (in this section referred to as the ''Trust Fund''). The Trust Fund shall consist of such gifts and bequests as may be made as provided in subparagraph (B) and such amounts as may be deposited in, or appropriated to, such Trust Fund as provided in subsection (a)(4), sections 731(b), 732(b), and 741(b) of this Act, and title XI of the Social Security Act.

(B) AUTHORIZATION TO ACCEPT GIFTS.—The Managing Trustee of the Trust Fund is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Trust Fund, for the benefit of

the Trust Fund, or any activity financed through the Trust Fund.

(2) MANAGEMENT.—

(A) IN GENERAL.—The Trust Fund shall be managed by the Secretary and the Attorney General through a Managing Trustee designated by the Secretary and the Attorney General.

(B) INVESTMENT OF FUNDS.—

(i) IN GENERAL.—It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in the Managing Trustee's judgment, required to meet current withdrawals.

(ii) GENERAL FORM OF INVESTMENT.—Investments described in clause (i) may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired—

(I) on original issue at the issue price, or

(II) by purchase of outstanding obligations at market price.

(iii) ISSUANCE OF PUBLIC-DEBT OBLIGATIONS.—The purposes for which obligations of the United States may be issued under chapter 31 of title 31, United States Code, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month, except that where such average is not a multiple of ⅛ of 1 percent, the rate of interest on such obligations shall be the

multiple of ⅛ of 1 percent nearest such market yield.

(iv) PURCHASES OF OTHER OBLIGATIONS.—The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where the Managing Trustee determines that the purchase of such other obligations is in the public interest.

(C) SALE OF OBLIGATIONS.—Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

(D) INTEREST ON OBLIGATIONS AND PROCEEDS FROM SALE OR REDEMPTION OF OBLIGATIONS.—The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

(E) RECEIPTS AND DISBURSEMENTS NOT INCLUDED IN UNITED STATES GOVERNMENT BUDGET TOTALS.—The receipts and disbursements of the Secretary and the Attorney General in the discharge of the functions of the Secretary and the Attorney General under the all-payer fraud and abuse control program established under subsection (a) shall not be included in the totals of the budget of the United States Government. For purposes of part C of the Balanced Budget and Emergency Deficit Control Act of 1985, the Secretary, the Attorney General, and the Trust Fund shall be treated in the same manner as the Federal Retirement Thrift Investment Board and the Thrift Savings Fund, respectively. The United States is not liable for any obligation or liability incurred by the Trust Fund.

(3) USE OF FUNDS.—

(A) IN GENERAL.—Amounts in the Trust Fund shall be used without regard to fiscal year limitation to assist the Inspector General of the Department of Health and Human Services and the Attorney General in carrying out the all-

payer fraud and abuse control program established under subsection (a).

(B) OVERALL ADMINISTRATION.—The Managing Trustee shall also pay from time to time from the Trust Fund such amounts as the Secretary and the Attorney General certify are necessary to carry out the all-payer fraud and abuse control program established under subsection (a).

(4) ANNUAL REPORT.—The Managing Trustee shall be required to submit an annual report to Congress on the amount of revenue which is generated and disbursed by the Trust Fund in each fiscal year. Such report shall include an estimate of the amount of additional appropriations authorized under subsection (a)(4) necessary for the Secretary and the Attorney General to conduct the all-payer fraud and abuse program established under subsection (a) in the next fiscal year.

SEC. 702. APPLICATION OF FEDERAL HEALTH ANTI-FRAUD AND ABUSE SANCTIONS TO ALL FRAUD AND ABUSE AGAINST ANY HEALTH CARE PLAN.

(a) CIVIL MONETARY PENALTIES.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended as follows:

(1) In subsection (a)(1), by inserting ''or of any health care plan (as defined in section 1128(i)),'' after ''subsection (i)(1)),''.

(2) In subsection (b)(1)(A), by inserting ''or under a health care plan'' after ''title XIX''.

(3) In subsection (f)—

(A) by redesignating paragraph (3) as paragraph (4); and

(B) by inserting after paragraph (2) the following new paragraphs:

''(3) With respect to amounts recovered arising out of a claim under a health care plan, the portion of such amounts as is determined to have been paid by the plan shall be repaid to the plan, and the portion of such amounts attributable to the amounts recovered under this section by reason of the amendments made by title VII of the America's Health Care Option Act (as estimated by the Secretary) shall be deposited into the Anti-Fraud and Abuse Trust Fund established under section 701(b) of such Act.''.

(4) In subsection (i)—

(A) in paragraph (2), by inserting ''or under a health care plan'' before the period at the end, and

(B) in paragraph (5), by inserting ''or under a health care plan'' after ''or XX''.

(b) CRIMES.—

(1) SOCIAL SECURITY ACT.—Section 1128B of such Act (42 U.S.C. 1320a–7b) is amended as follows:

(A) In the heading, by adding at the end the following: ''OR HEALTH CARE PLANS''.

(B) In subsection (a)(1)—

(i) by striking ''title XVIII or'' and inserting ''title XVIII,'', and

(ii) by adding at the end the following: ''or a health care plan (as defined in section 1128(i)),''.

(C) In subsection (a)(5), by striking ''title XVIII or a State health care program'' and inserting ''title XVIII, a State health care program, or a health care plan''.

(D) In the second sentence of subsection (a)—

(i) by inserting after ''title XIX'' the following: ''or a health care plan'', and

(ii) by inserting after ''the State'' the following: ''or the plan''.

(E) In subsection (b)(1), by striking ''title XVIII or a State health care program'' each place it appears and inserting ''title XVIII, a State health care program, or a health care plan''.

(F) In subsection (b)(2), by striking ''title XVIII or a State health care program'' each place it appears and inserting ''title XVIII, a State health care program, or a health care plan''.

(G) In subsection (b)(3), by striking ''title XVIII or a State health care program'' each place it appears in subparagraphs (A) and (C) and inserting ''title XVIII, a State health care program, or a health care plan''.

(H) In subsection (d)(2)—

(i) by striking ''title XIX,'' and inserting ''title XIX or under a health care plan,'', and

(ii) by striking ''State plan,'' and inserting ''State plan or the health care plan,''.

(2) IDENTIFICATION OF COMMUNITY SERVICE OPPORTUNITIES.—Section 1128B of such Act (42

U.S.C. 1320a–7b) is further amended by adding at the end the following new subsection:

''(f) The Secretary may—

''(1) in consultation with State and local health care officials, identify opportunities for the satisfaction of community service obligations that a court may impose upon the conviction of an offense under this section, and

''(2) make information concerning such opportunities available to Federal and State law enforcement officers and State and local health care officials.''.

(c) HEALTH CARE PLAN DEFINED.—Section 1128 of such Act (42 U.S.C. 1320a–7) is amended by redesignating subsection (i) as subsection (j) and by inserting after subsection (h) the following new subsection:

''(i) HEALTH CARE PLAN DEFINED.—For purposes of sections 1128A and 1128B, the term 'health care plan' means a public or private program for the delivery of or payment for health care items or services other than the medicare program, the medicaid program, or a State health care program.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1995.

SEC. 703. HEALTH CARE FRAUD AND ABUSE GUIDANCE.

(a) SOLICITATION AND PUBLICATION OF MODIFICATIONS TO EXISTING SAFE HARBORS AND NEW SAFE HARBORS.—

(1) IN GENERAL.—

(A) SOLICITATION OF PROPOSALS FOR SAFE HARBORS.—Not later than January 1, 1995, and not less than annually thereafter, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for—

(i) modifications to existing safe harbors issued pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987 (42 U.S.C. 1320a–7b note);

(ii) additional safe harbors specifying payment practices that shall not be treated as a criminal offense under section 1128B(b) of the Social Security Act the (42 U.S.C. 1320a–7b(b)) and shall not serve as the basis for an exclusion under section 1128(b)(7) of such Act (42 U.S.C. 1320a–7(b)(7));

(iii) interpretive rulings to be issued pursuant to subsection (b); and

(iv) special fraud alerts to be issued pursuant to subsection (c).

(B) PUBLICATION OF PROPOSED MODIFICATIONS AND PROPOSED ADDITIONAL STATE HARBORS.—After considering the proposals described in clauses (i) and (ii) of subparagraph (A), the Secretary, in consultation with the Attorney General, shall publish in the Federal Register proposed modifications to existing safe harbors and proposed additional safe harbors, if appropriate, with a 60-day comment period. After considering any public comments received during this period, the Secretary shall issue final rules modifying the existing safe harbors and establishing new safe harbors, as appropriate.

(C) REPORT.—The Inspector General of the Department of Health and Human Services (hereafter in this section referred to as the ''Inspector General'') shall, in an annual report to Congress or as part of the year-end semiannual report required by section 5 of the Inspector General Act of 1978 (5 U.S.C. App.), describe the proposals received under clauses (i) and (ii) of subparagraph (A) and explain which propos-

als were included in the publication described in subparagraph (B), which proposals were not included in that publication, and the reasons for the rejection of the proposals that were not included.

(2) CRITERIA FOR MODIFYING AND ESTABLISHING SAFE HARBORS.—In modifying and establishing safe harbors under paragraph (1)(B), the Secretary may consider the extent to which providing a safe harbor for the specified payment practice may result in any of the following:

(A) An increase or decrease in access to health care services.

(B) An increase or decrease in the quality of health care services.

(C) An increase or decrease in patient freedom of choice among health care providers.

(D) An increase or decrease in competition among health care providers.

(E) An increase or decrease in the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

(F) An increase or decrease in the cost to Government health care programs.

(G) An increase or decrease in the potential overutilization of health care services.

(H) The existence or nonexistence of any potential financial benefit to a health care professional or provider which may vary based on their decisions of—

(i) whether to order a health care item or service; or

(ii) whether to arrange for a referral of health care items or services to a particular practitioner or provider.

(I) Any other factors the Secretary deems appropriate in the interest of preventing fraud and abuse in Government health care programs.

(b) INTERPRETIVE RULINGS.—

(1) IN GENERAL.—

(A) REQUEST FOR INTERPRETIVE RULING.—Any person may present, at any time, a request to the Inspector General for a statement of the Inspector General's current interpretation of the meaning of a specific aspect of the application of sections 1128A and 1128B of the Social Security Act (hereafter in this section referred to as an ''interpretive ruling'').

(B) ISSUANCE AND EFFECT OF INTERPRETIVE RULING.—

(i) IN GENERAL.—If appropriate, the Inspector General shall in consultation with the Attorney General, issue an interpretive ruling in response to a request described in subparagraph (A). Interpretive rulings shall not have the force of law and shall be treated as an interpretive rule within the meaning of section 553(b) of title 5, United States Code. All interpretive rulings issued pursuant to this provision shall be published in the Federal Register or otherwise made available for public inspection.

(ii) REASONS FOR DENIAL.—If the Inspector General does not issue an interpretive ruling in response to a request described in subparagraph (A), the Inspector General shall notify the requesting party of such decision and shall identify the reasons for such decision.

(2) CRITERIA FOR INTERPRETIVE RULINGS.—

(A) IN GENERAL.—In determining whether to issue an interpretive ruling under paragraph (1)(B), the Inspector General may consider—

(i) whether and to what extent the request identifies an ambiguity within the language of the statute, the existing safe harbors, or previous interpretive rulings; and

(ii) whether the subject of the requested interpretive ruling can be adequately addressed by interpretation of the language of the statute, the existing safe harbor rules, or previous interpretive rulings, or whether the request would require a substantive ruling not authorized under this subsection.

(B) NO RULINGS ON FACTUAL ISSUES.—The Inspector General shall not give an interpretive ruling on any factual issue, including the intent of the parties or the fair market value of particular leased space or equipment.

(c) SPECIAL FRAUD ALERTS.—

(1) IN GENERAL.—

(A) REQUEST FOR SPECIAL FRAUD ALERTS.—Any person may present, at any

time, a request to the Inspector General for a notice which informs the public of practices which the Inspector General considers to be suspect or of particular concern under section 1128B(b) of the Social Security Act (42 U.S.C. 1320a–7b(b)) (hereafter in this subsection referred to as a ''special fraud alert'').

(B) ISSUANCE AND PUBLICATION OF SPECIAL FRAUD ALERTS.—Upon receipt of a request described in subparagraph (A), the Inspector General shall investigate the subject matter of the request to determine whether a special fraud alert should be issued. If appropriate, the Inspector General shall in consultation with the Attorney General, issue a special fraud alert in response to the request. All special fraud alerts issued pursuant to this subparagraph shall be published in the Federal Register.

(2) CRITERIA FOR SPECIAL FRAUD ALERTS.—In determining whether to issue a special fraud alert upon a request described in paragraph (1), the Inspector General may consider—

(A) whether and to what extent the practices that would be identified in the special

fraud alert may result in any of the consequences described in subsection (a)(2); and

(B) the volume and frequency of the conduct that would be identified in the special fraud alert.

SEC. 704. REPORTING OF FRAUDULENT ACTIONS UNDER MEDICARE.

Not later than 1 year after the date of the enactment of this Act, the Secretary shall establish a program through which individuals entitled to benefits under the medicare program may report to the Secretary on a confidential basis (at the individual's request) instances of suspected fraudulent actions arising under the program by providers of items and services under the program.

Subtitle B—Revisions to Current Sanctions for Fraud and Abuse

SEC. 711. MANDATORY EXCLUSION FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

(a) INDIVIDUAL CONVICTED OF FELONY RELATING TO FRAUD.—

(1) IN GENERAL.—Section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7(a)) is amended by adding at the end the following new paragraph:

''(3) FELONY CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.''.

(2) CONFORMING AMENDMENT.—Section 1128(b)(1) of such Act (42 U.S.C. 1320a–7(b)(1)) is amended—

(A) in the heading, by striking ''CONVICTION'' and inserting ''MISDEMEANOR CONVICTION''; and

(B) by striking ''criminal offense'' and inserting ''criminal offense consisting of a misdemeanor''.

(b) INDIVIDUAL CONVICTED OF FELONY RELATING TO CONTROLLED SUBSTANCE.—

(1) IN GENERAL.—Section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7(a)), as amend-

ed by subsection (a), is amended by adding at the end the following new paragraph:

''(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.''.

(2) CONFORMING AMENDMENT.—Section 1128(b)(3) of such Act (42 U.S.C. 1320a–7(b)(3)) is amended—

(A) in the heading, by striking ''CONVICTION'' and inserting ''MISDEMEANOR CONVICTION''; and

(B) by striking ''criminal offense'' and inserting ''criminal offense consisting of a misdemeanor''.

SEC. 712. ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.

Section 1128(c)(3) of the Social Security Act (42 U.S.C. 1320a–7(c)(3)) is amended by adding at the end the following new subparagraphs:

''(D) In the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

''(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

''(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.''.

SEC. 713. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH OWNERSHIP OR CONTROL INTEREST IN SANCTIONED ENTITIES.

Section 1128(b) of the Social Security Act (42 U.S.C. 1320a–7(b)) is amended by adding at the end the following new paragraph:

''(15) INDIVIDUALS CONTROLLING A SANCTIONED ENTITY.—Any individual who has a direct

or indirect ownership or control interest of 5 percent or more, or an ownership or control interest (as defined in section 1124(a)(3)) in, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of, an entity—

''(A) that has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection;

''(B) against which a civil monetary penalty has been assessed under section 1128A; or

''(C) that has been excluded from participation under a program under title XVIII or under a State health care program.''.

SEC. 714. CIVIL MONETARY PENALTIES.

(a) PROHIBITION AGAINST OFFERING INDUCEMENTS TO INDIVIDUALS ENROLLED UNDER OR EMPLOYED BY PROGRAMS OR PLANS.—

(1) INDUCEMENTS TO INDIVIDUALS ENROLLED UNDER MEDICARE.—

(A) OFFER OF REMUNERATION.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended—

(i) by striking ''or'' at the end of paragraph (1)(D);

(ii) by striking ‘‘, or’’ at the end of paragraph (2) and inserting a semicolon;

(iii) by striking the semicolon at the end of paragraph (3) and inserting ‘‘; or’’; and

(iv) by inserting after paragraph (3) the following new paragraph:

‘‘(4) offers to or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program;’’.

(B) REMUNERATION DEFINED.—Section 1128A(i) is amended by adding the following new paragraph:

‘‘(6) The term ‘remuneration’ includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value. The term ‘remuneration’ does not include the waiver of coinsurance and deductible amounts by a person, if—

''(A) the waiver is not offered as part of any advertisement or solicitation;

''(B) the person does not routinely waive coinsurance or deductible amounts; and

''(C) the person—

''(i) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need;

''(ii) fails to collect coinsurance or deductible amounts after making reasonable collection efforts; or

''(iii) provides for any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary.''.

(2) INDUCEMENTS TO EMPLOYEES.—Section 1128A(a) of such Act (42 U.S.C. 1320a–7a(a)), as amended by paragraph (1), is further amended—

(A) by striking ''or'' at the end of paragraph (3);

(B) by striking the semicolon at the end of paragraph (4) and inserting ''; or''; and

(C) by inserting after paragraph (4) the following new paragraph:

''(5) pays a bonus, reward, or any other remuneration, directly or indirectly, to an employee to induce the employee to encourage individuals to seek or obtain covered items or services for which payment may be made under the medicare program, or a State health care program where the amount of the remuneration is determined in a manner that takes into account (directly or indirectly) the value or volume of any referrals by the employee to the employer for covered items or services;''.

(b) EXCLUDED INDIVIDUAL RETAINING OWNERSHIP OR CONTROL INTEREST IN PARTICIPATING ENTITY.—Section 1128A(a) of such Act, as amended by subsection (a), is further amended—

(1) by striking ''or'' at the end of paragraph (4);

(2) by striking the semicolon at the end of paragraph (5) and inserting ''; or''; and

(3) by inserting after paragraph (5) the following new paragraph:

''(6) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under title XVIII or a State health care program in accordance with this subsection or under section 1128 and who, at the

time of a violation of this subsection, retains a direct or indirect ownership or control interest of 5 percent or more, or an ownership or control interest (as defined in section 1124(a)(3)) in, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of, an entity that is participating in a program under title XVIII or a State health care program;''.

(c) MISUSE OF HEALTH SECURITY CARD OR UNIQUE HEALTH IDENTIFIER.—Section 1128A(a) of such Act, as amended by subsection (b), is further amended—

(1) by striking ''or'' at the end of paragraph (5);

(2) by striking the semicolon at the end of paragraph (6) and inserting ''; or''; and

(3) by inserting after paragraph (6) the following new paragraphs:

''(7) requires the display of, requires the use of, or uses a health security card that is issued under subtitle B of this title for any purpose other than a purpose described in such subtitle;

''(8) requires the disclosure of, requires the use of, or uses an individual's unique health identifier established under subtitle B of this title for any purpose that is not authorized by the Secretary;''.

(d) MODIFICATIONS OF AMOUNTS OF PENALTIES AND ASSESSMENTS.—Section 1128A(a) of such Act (42 U.S.C. 1320a–7a(a)), as amended by subsections (a) and (b), is amended in the matter following paragraph (6)—

(1) by striking ''$2,000'' and inserting ''$10,000'';

(2) by inserting ''; in cases under paragraph (4), $10,000 for each such offer or transfer; in cases under paragraph (5), $10,000 for each such payment; in cases under paragraph (6), $10,000 for each day the prohibited relationship occurs; in cases under paragraph (7) or (8), $10,000 per violation'' after ''false or misleading information was given'';

(3) by striking ''twice the amount'' and inserting ''3 times the amount''; and

(4) by inserting ''(or, in cases under paragraphs (4) and (5), 3 times the amount of the illegal remuneration)'' after ''for each such item or service''.

(e) CLAIM FOR ITEM OR SERVICE BASED ON INCORRECT CODING OR MEDICALLY UNNECESSARY SERVICES.—Section 1128A(a)(1) of such Act (42 U.S.C. 1320a–7a(a)(1)) is amended—

(1) in subparagraph (A) by striking ''claimed,'' and inserting the following: ''claimed, including any person who presents or causes to be presented a

claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided,'';

(2) in subparagraph (C), by striking ''or'' at the end;

(3) in subparagraph (D), by striking ''; or'' and inserting '', or''; and

(4) by inserting after subparagraph (D) the following new subparagraph:

''(E) is for a medical or other item or service that a person knows or should know is not medically necessary; or''.

SEC. 715. ACTIONS SUBJECT TO CRIMINAL PENALTIES.

(a) PERMITTING SECRETARY TO IMPOSE CIVIL MONETARY PENALTY.—Section 1128A(b) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended by adding the following new paragraph:

''(3) Any person (including any organization, agency, or other entity, but excluding a beneficiary as defined in subsection (i)(5)) who the Secretary determines has violated section 1128B(b) of this title shall be subject to a civil monetary penalty of not more than $10,000 for each such violation. In

addition, such person shall be subject to an assessment of not more than twice the total amount of the remuneration offered, paid, solicited, or received in violation of section 1128B(b). The total amount of remuneration subject to an assessment shall be calculated without regard to whether some portion thereof also may have been intended to serve a purpose other than one proscribed by section 1128B(b).''.

(b) RESTRICTION ON APPLICATION OF EXCEPTION FOR AMOUNTS PAID TO EMPLOYEES.—Section 1128B(b)(3)(B) of such Act (42 U.S.C. 1320a–7b(b)(3)(B)) is amended by striking ''services;'' and inserting the following: ''services, but only if the amount of remuneration under the arrangement is (i) consistent with fair market value; (ii) not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the employee to the employer for the furnishing (or arranging for the furnishing) of such items or services; and (iii) provided pursuant to an arrangement that would be commercially reasonable even if no referrals were made;''.

SEC. 716. SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.

(a) MINIMUM PERIOD OF EXCLUSION FOR PRACTITIONERS AND PERSONS FAILING TO MEET STATUTORY OBLIGATIONS.—

(1) IN GENERAL.—The second sentence of section 1156(b)(1) of the Social Security Act (42 U.S.C. 1320c–5(b)(1)) is amended by striking ''may prescribe)'' and inserting ''may prescribe, except that such period may not be less than 1 year)''.

(2) CONFORMING AMENDMENT.—Section 1156(b)(2) of such Act (42 U.S.C. 1320c–5(b)(2)) is amended by striking ''shall remain'' and inserting ''shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain''.

(b) REPEAL OF ''UNWILLING OR UNABLE'' CONDITION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1) of such Act (42 U.S.C. 1320c–5(b)(1)) is amended—

(1) in the second sentence, by striking ''and determines'' and all that follows through ''such obligations,''; and

(2) by striking the third sentence.

(c) AMOUNT OF CIVIL MONEY PENALTY.—Section 1156(b)(3) of such Act (42 U.S.C. 1320c–5(b)(3)) is

amended by striking ''the actual or estimated cost'' and inserting the following: ''up to $10,000 for each instance''.

SEC. 717. INTERMEDIATE SANCTIONS FOR MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.

(a) APPLICATION OF INTERMEDIATE SANCTIONS FOR ANY PROGRAM VIOLATIONS.—

(1) IN GENERAL.—Section 1876(i)(1) of the Social Security Act (42 U.S.C. 1395mm(i)(1)) is amended by striking ''the Secretary may terminate'' and all that follows and inserting the following: ''in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—

''(A) has failed substantially to carry out the contract;

''(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section;

''(C) is operating in a manner that is not in the best interests of the individuals covered under the contract; or

''(D) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).''.

(2) OTHER INTERMEDIATE SANCTIONS FOR MISCELLANEOUS PROGRAM VIOLATIONS.—Section 1876(i)(6) of such Act (42 U.S.C. 1395mm(i)(6)) is amended by adding at the end the following new subparagraph:

''(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1) the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

''(i) Civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

''(ii) Civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists.

''(iii) Suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.''.

(3) PROCEDURES FOR IMPOSING SANCTIONS.—Section 1876(i) of such Act (42 U.S.C. 1395mm(i)) is amended by adding at the end the following new paragraph:

''(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

''(A) the Secretary provides the organization with the opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1);

''(B) in deciding whether to impose sanctions, the Secretary considers aggravating factors such as whether an entity has a history of deficiencies or has

not taken action to correct deficiencies the Secretary has brought to their attention;

''(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

''(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.''.

(4) CONFORMING AMENDMENTS.—

(A) IN GENERAL.—Section 1876(i)(6)(B) of such Act (42 U.S.C. 1395mm(i)(6)(B)) is amended by striking the second sentence.

(B) PROCEDURAL PROVISIONS.—Section 1876(i)(6) of such Act (42 U.S.C. 1395mm(i)(6)) is further amended by adding at the end the following new subparagraph:

''(D) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (A) or (B) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).''.

(b) AGREEMENTS WITH PEER REVIEW ORGANIZATIONS.—

(1) REQUIREMENT FOR WRITTEN AGREEMENT.—Section 1876(i)(7)(A) of the Social Security Act (42 U.S.C. 1395mm(i)(7)(A)) is amended by striking ''an agreement'' and inserting ''a written agreement''.

(2) DEVELOPMENT OF MODEL AGREEMENT.—Not later than July 1, 1995, the Secretary shall develop a model of the agreement that an eligible organization with a risk-sharing contract under section 1876 of the Social Security Act must enter into with an entity providing peer review services with respect to services provided by the organization under section 1876(i)(7)(A) of such Act.

(3) REPORT BY GAO.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study of the costs incurred by eligible organizations with risk-sharing contracts under section 1876(b) of such Act of complying with the requirement of entering into a written agreement with an entity providing peer review services with respect to services provided by the organization, together with an analysis of how information generated by such entities is used by the Secretary

to assess the quality of services provided by such eligible organizations.

(B) REPORT TO CONGRESS.—Not later than July 1, 1997, the Comptroller General shall submit a report to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance and the Special Committee on Aging of the Senate on the study conducted under subparagraph (A).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contract years beginning on or after January 1, 1995.

SEC. 718. EFFECTIVE DATE.

The amendments made by this subtitle shall take effect January 1, 1995.

Subtitle C—Administrative and Miscellaneous Provisions

SEC. 721. ESTABLISHMENT OF THE HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM.

(a) FINDINGS.—The Congress finds the following:

(1) Fraud and abuse with respect to the delivery of and payment for health care services is a significant contributor to the growing costs of the Nation's health care.

(2) Control of fraud and abuse in health care services warrants greater efforts of coordination than those that can be undertaken by individual States or the various Federal, State, and local law enforcement programs.

(3) There is a national need to coordinate information about health care providers and entities that have engaged in fraud and abuse in the delivery of and payment for health care services.

(4) There is no comprehensive national data collection program for the reporting of public information about final adverse actions against health care providers, suppliers, or licensed health care practitioners that have engaged in fraud and abuse in the delivery of and payment for health care services.

(5) A comprehensive national data collection program for the reporting of public information about final adverse actions will facilitate the enforcement of the provisions of the Social Security Act and other statutes applicable to health care fraud and abuse.

(b) GENERAL PURPOSE.—Not later than January 1, 1995, the Secretary shall establish a national health care fraud and abuse data collection program for the reporting

of final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (c), with access as set forth in subsection (d).

(c) REPORTING OF INFORMATION.—

(1) IN GENERAL.—Each government agency and health care plan shall report any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier, or practitioner.

(2) INFORMATION TO BE REPORTED.—The information to be reported under paragraph (1) includes:

(A) The name of any health care provider, supplier, or practitioner who is the subject of a final adverse action.

(B) The name (if known) of any health care entity with which a health care provider, supplier, or practitioner is affiliated or associated.

(C) The nature of the final adverse action.

(D) A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information as the Secretary determines by regulation is required

for appropriate interpretation of information reported under this section.

(3) CONFIDENTIALITY.—In determining what information is required, the Secretary shall include procedures to assure that the privacy of individuals receiving health care services is appropriately protected.

(4) TIMING AND FORM OF REPORTING.—The information required to be reported under this subsection shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary prescribes. Such information shall first be required to be reported on a date specified by the Secretary.

(5) TO WHOM REPORTED.—The information required to be reported under this subsection shall be reported to the Secretary.

(d) DISCLOSURE AND CORRECTION OF INFORMATION.—

(1) DISCLOSURE.—With respect to the information about final adverse actions (not including settlements in which no findings of liability have been made) reported to the Secretary under this section respecting a health care provider, supplier, or practi-

tioner, the Secretary shall, by regulation, provide for—

(A) disclosure of the information, upon request, to the health care provider, supplier, or licensed practitioner, and

(B) procedures in the case of disputed accuracy of the information.

(2) CORRECTIONS.—Each Government agency and health care plan shall report corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, in such form and manner that the Secretary prescribes by regulation.

(e) ACCESS TO REPORTED INFORMATION.—

(1) AVAILABILITY.—The information in this database shall be available to Federal and State government agencies and health care plans pursuant to procedures that the Secretary shall provide by regulation.

(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information in this database. The amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the Sec-

retary or, in the Secretary's discretion to the agency designated under this section to cover such costs.

(f) PROTECTION FROM LIABILITY FOR REPORTING.—No person or entity, including the agency designated by the Secretary in subsection (c)(5) shall be held liable in any civil action with respect to any report made as required by this section, without knowledge of the falsity of the information contained in the report.

(g) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

(1) The term ''final adverse action'' includes:

(A) Civil judgments against a health care provider in Federal or State court related to the delivery of a health care item or service.

(B) Federal or State criminal convictions related to the delivery of a health care item or service.

(C) Actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including—

(i) formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation,

(ii) any other loss of license of the provider, supplier, or practitioner, by operation of law, or

(iii) any other negative action or finding by such Federal or State agency that is publicly available information.

(D) Exclusion from participation in Federal or State health care programs.

(E) Any other adjudicated actions or decisions that the Secretary shall establish by regulation.

(2) The terms ''licensed health care practitioner'', ''licensed practitioner'', and ''practitioner'' mean, with respect to a State, an individual who is licensed or otherwise authorized by the State to provide health care services (or any individual who, without authority holds himself or herself out to be so licensed or authorized).

(3) The term ''health care provider'' means a provider of services as defined in section 1861(u) of the Social Security Act, and any entity, including a health maintenance organization, group medical practice, or any other entity listed by the Secretary in regulation, that provides health care services.

(4) The term ''supplier'' means a supplier of health care items and services described in section 1819 (a) and (b), and section 1861 of the Social Security Act.

(5) The term ''Government agency'' shall include:

(A) The Department of Justice.

(B) The Department of Health and Human Services.

(C) Any other Federal agency that either administers or provides payment for the delivery of health care services, including, but not limited to the Department of Defense and the Veterans' Administration.

(D) State law enforcement agencies.

(E) State medicaid fraud and abuse units.

(F) Federal or State agencies responsible for the licensing and certification of health care providers and licensed health care practitioners.

(6) The term ''health care plan'' has the meaning given to such term by section 1128(i) of the Social Security Act.

(7) For purposes of paragraph (2), the existence of a conviction shall be determined under para-

graph (4) of section 1128(j) of the Social Security Act.

(h) CONFORMING AMENDMENT.—Section 1921(d) of the Social Security Act is amended by inserting ''and section 721 of the America's Health Care Option Act'' after ''section 422 of the Health Care Quality Improvement Act of 1986''.

Subtitle D—Amendments to Criminal Law

SEC. 731. HEALTH CARE FRAUD.

(a) IN GENERAL.—

(1) FINES AND IMPRISONMENT FOR HEALTH CARE FRAUD VIOLATIONS.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following new section:

"§ 1347. Health care fraud

''(a) Whoever knowingly executes, or attempts to execute, a scheme or artifice—

''(1) to defraud any health care plan or other person, in connection with the delivery of or payment for health care benefits, items, or services; or

''(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care plan, or person in con-

nection with the delivery of or payment for health care benefits, items, or services;

shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365(g)(3) of this title), such person shall be imprisoned for any term of years.

''(b) For purposes of this section, the term 'health care plan' means a federally funded public program, or a private plan or other arrangement for the delivery of or payment for health care items or services.''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 63 of title 18, United States Code, is amended by adding at the end the following:

''1347. Health care fraud.''.

(b) CRIMINAL FINES DEPOSITED IN THE ANTI-FRAUD AND ABUSE TRUST FUND.—The Secretary of the Treasury shall deposit into the Anti-Fraud and Abuse Trust Fund established under section 701(b) an amount equal to the criminal fines imposed under section 1347 of title 18, United States Code (relating to health care fraud).

SEC. 732. FORFEITURES FOR FEDERAL HEALTH CARE OFFENSES.

(a) IN GENERAL.—Section 982(a) of title 18, United States Code, is amended by adding after paragraph (5) the following new paragraph:

''(6)(A) The court, in imposing sentence on a person convicted of a Federal health care offense, shall order the person to forfeit property, real or personal, that—

''(i) is used in the commission of the offense if the offense results in a financial loss or gain of $50,000 or more; or

''(ii) constitutes or is derived from proceeds traceable to the commission of the offense.

''(B) For purposes of this paragraph, the term 'Federal health care offense' means a violation of, or a criminal conspiracy to violate—

''(i) section 1347 of this title;

''(ii) section 1128B of the Social Security Act;

''(iii) sections 287, 371, 664, 666, 1001, 1027, 1341, 1343, or 1954 of this title if the violation or conspiracy relates to health care fraud; and

''(iv) section 501 or 511 of the Employee Retirement Income Security Act of 1974, if the violation or conspiracy relates to health care fraud.''.

(b) PROPERTY FORFEITED DEPOSITED IN ANTI-FRAUD AND ABUSE TRUST FUND.—The Secretary of the

Treasury shall deposit into the Anti-Fraud and Abuse Trust Fund established under section 701(b) an amount equal to amounts resulting from forfeiture of property by reason of a Federal health care offense pursuant to section 982(a)(6) of title 18, United States Code.

SEC. 733. INJUNCTIVE RELIEF RELATING TO FEDERAL HEALTH CARE OFFENSES.

Section 1345(a)(1) of title 18, United States Code, is amended—

(1) by striking ''or'' at the end of subparagraph (A);

(2) by inserting ''or'' at the end of subparagraph (B); and

(3) by adding at the end the following:

''(C) committing or about to commit a Federal health care offense (as defined in section 982(a)(6)(B) of this title);''.

Subtitle E—Amendments to Civil False Claims Act

SEC. 741. AMENDMENTS TO CIVIL FALSE CLAIMS ACT.

(a) IN GENERAL.—Section 3729 of title 31, United States Code, is amended—

(1) in subsection (a)(7), by inserting ''or to a health care plan,'' after ''property to the Government,'';

(2) in the matter following subsection (a)(7), by inserting ''or health care plan'' before ''sustains because of the act of that person,'';

(3) at the end of the first sentence of subsection (a), by inserting ''or health care plan'' before ''sustains because of the act of the person.'';

(4) in subsection (c)—

(A) by inserting ''the term'' after ''section,''; and

(B) by adding at the end the following: ''The term also includes any request or demand, whether under contract or otherwise, for money or property which is made or presented to a health care plan.''; and

(5) by adding at the end the following:

''(f) HEALTH CARE PLAN DEFINED.—For purposes of this section, the term 'health care plan' means a federally funded public program for the delivery of or payment for health care items or services.''.

(b) PENALTIES AND DAMAGES DEPOSITED INTO THE ANTI-FRAUD AND ABUSE TRUST FUND.—The Secretary of the Treasury shall deposit into the Anti-Fraud and Abuse Trust Fund established under section 701(b) an amount equal to penalties and damages imposed under section 3729 of title 31, United States Code, in cases in-

volving claims related to the provision of health care items and services (other than funds awarded to a relator or for restitution).

TITLE VIII—MEDICARE AND MEDICAID

SEC. 800. REFERENCES TO SOCIAL SECURITY ACT.

Except as otherwise specifically provided, whenever in this title an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

Subtitle A—Medicare

PART I—INTEGRATION OF MEDICARE BENEFICIARIES INTO THE PRIVATE MARKET

SEC. 801. STUDY ON INTEGRATION OF MEDICARE BENEFICIARIES.

(a) IN GENERAL.—The Secretary of Health and Human Services (hereafter in this section referred to as the ''Secretary'') shall study—

(1) allowing payment under title XVIII of the Social Security Act on behalf of medicare beneficiaries that opt—

(A) to enroll in certified health plans (as defined in section 21003(b) of the Social Security Act); and

(B) to establish medical savings accounts (in accordance with section 213 of the America's Health Care Option Act); and

(2) allowing payment under title XVIII of the Social Security Act on behalf of medicare beneficiaries who are military retirees that opt to enroll in health plans sponsored by the Department of Defense or other appropriate Federal health care programs.

(b) RECOMMENDATIONS.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit recommendations to Congress on each of the matters studied under subsection (a).

SEC. 802. IMPROVEMENTS TO RISK CONTRACTS.

(a) RATING AREAS.—Section 1876(a)(1)(F)(ii) (42 U.S.C. 1395mm(a)(1)(F)(ii)) is amended by striking ''county (or equivalent area)'' and inserting ''Metropolitan Statistical Area (as defined by the Office of Management and Budget), New England County Metropolitan Area, or other appropriate geographic area outside a Metropolitan Statistical Area or a New England County Metropolitan Area (hereafter in this section referred to as a 'rating area')''.

(b) PERIOD OF ENROLLMENT.—Section 1876(c)(3) (42 U.S.C. 1395mm(c)(3)) is amended—

(1) in subparagraph (A)(i), after ''of at least 30 days duration every year'', by inserting ''(which may be specified by the Secretary)'';

(2) in subparagraph (B), by striking ''as of'' and inserting '', at the option of the organization, (i) during an annual period as approved by the Secretary, or (ii) as of'';

(3) in subparagraph (E)—

(A) by striking ''and'' in clause (iv),

(B) by striking the period in clause (v) and inserting '', and'', and

(C) by adding at the end the following new clause:

''(vi) the option chosen by the plan under clause (i) or (ii) of subparagraph (B) with respect to termination of enrollment by an individual.''.

(c) MARKETING MATERIALS.—Section 1876(c)(3)(C) (42 U.S.C. 1395mm(c)(3)(C)) is amended by adding at the end the following: ''The Secretary shall develop comparative materials with respect to all eligible organizations in an area (and with respect to the program established under this title for individuals not enrolled with such an organization) for distribution by such organizations or the

Secretary to individuals eligible to enroll under this section.''.

(d) FIFTY-FIFTY RULE.—Section 1876(f) (42 U.S.C. 1395mm(f)) is amended—

(1) by amending paragraph (2) to read as follows:

''(2) The Secretary may modify or waive the requirement imposed by paragraph (1) if an eligible organization demonstrates that it provides for adequate quality of care for individuals enrolled under this section by—

''(A) meeting the quality standards for organizations with contracts under this section;

''(B) meeting the fiscal soundness requirements under this section;

''(C) demonstrating successful operational experience as an eligible organization under this section for at least the 3 years immediately preceding an application for a waiver under this paragraph; and

''(D) demonstrating that the number of individuals enrolled in the plan or its parent organization is at least 50,000 at the time of application for a waiver under this paragraph.

In making a determination under subparagraph (A) with respect to an eligible organization, the Secretary may accept quality performance standards as measured by private organizations acceptable to the Secretary or organizations designated by the Secretary, including peer review organizations.''; and

(2) by adding at the end the following new paragraph:

''(4) The Secretary may terminate the requirement under paragraph (1) when the Secretary determines that health plans have established alternative quality assurance mechanisms that effectively provide sufficient quality safeguards.''.

(e) REBATES.—Section 1876(g)(2) (42 U.S.C. 1395mm(g)(2)) is amended in the matter following subparagraph (B) by striking ''community rate (as so reduced); except'' and inserting ''community rate (as so reduced) or, at the election of the plan, a cash rebate equal to such difference; except''.

(f) DIRECT CALCULATION OF AAPCC.—Section 1876(a)(4) (42 U.S.C. 1395mm(a)(4)) is amended by striking ''actual experience'' and all that follows through ''actuarial equivalence)'' and inserting ''actual experience in a rating area''.

(g) DEMONSTRATION PROJECT.—

(1) IN GENERAL.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall establish a demonstration project under which any eligible organization that—

(A) has a risk contract under section 1876 of the Social Security Act (42 U.S.C. 1395mm), and

(B) serves individuals enrolled under such section in a rating area (as defined under section 1876(a)(1)(F)(ii) of such Act),

is paid, with respect to such individuals, on the basis of a payment methodology that blends market-based premiums and the average per capita fee-for-service costs for individuals eligible to enroll under such section for the area and gives greater weight to market-based premiums in areas in which a greater proportion of such individuals are enrolled with such organizations.

(2) DESIGNATION OF AREAS.—The Secretary may designate a rating area (as defined by the Secretary under section 1876(a)(1)(F)(ii) of the Social Security Act (42 U.S.C. 1395mm(a)(1)(F)(ii))) for participation in the demonstration established under paragraph (1) only if—

(A) the eligible organizations with a contract under section 1876 of the Social Security Act serving such area submit an application to participate in the demonstration project in such form and manner, and at such time, as the Secretary may designate, and

(B)(i) the rating area has more than one eligible organization with a contract serving such area,

(ii) the rating area has adequate enrollment of individuals who are entitled to benefits under part A of title XVIII of such Act in eligible organizations with a contract under section 1876 of such Act (as determined by the Secretary), and

(iii) the adjusted average per capita cost for such rating area for part B services under title XVIII of such Act as determined in accordance with such section is less than the United States per capita cost for part B services under such title.

(h) EXTENSION OF SOCIAL HEALTH MAINTENANCE ORGANIZATIONS.—Section 4018(b) of the Omnibus Budget Reconciliation Act of 1987, as amended by section 4207(b)(4)(B) of the Omnibus Budget Reconciliation Act

of 1990 and section 13567(a) of the Omnibus Budget Reconciliation Act of 1993, is amended—

(1) in paragraph (1), by striking ''December 31, 1997'' and inserting ''December 31, 1999''; and

(2) in paragraph (4), by striking ''March 31, 1998'' and inserting ''March 31, 2000''.

(i) MILITARY ADJUSTMENT.—Section 1876(a)(1)(B) (42 U.S.C. 1395mm(a)(1)(B)) is amended by inserting ''use or nonuse of Veteran's Administration, military treatment and uniformed services treatment facilities, and associated physicians, providers, and suppliers,'' after ''disability status,''.

(j) EFFECTIVE DATE.—The amendments made by subsections (a), (b), (c), (d), (e), (f), and (i) shall apply to contracts entered into or renewed on or after January 1, 1996.

SEC. 803. MEDICARE SELECT.

(a) AMENDMENTS TO PROVISIONS RELATING TO MEDICARE SELECT POLICIES.—

(1) PERMITTING MEDICARE SELECT POLICIES IN ALL STATES.—Subsection (c) of section 4358 of the Omnibus Budget Reconciliation Act of 1990 is hereby repealed.

(2) REQUIREMENTS OF MEDICARE SELECT POLICIES.—Section 1882(t)(1) (42 U.S.C. 1395ss(t)(1)) is amended to read as follows:

''(1)(A) If a medicare supplemental policy meets the requirements of the 1991 NAIC Model Regulation or 1991 Federal Regulation and otherwise complies with the requirements of this section except that—

''(i) the benefits under such policy are restricted to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), and

''(ii) in the case of a policy described in subparagraph (C)(i)—

''(I) the benefits under such policy are not one of the groups or packages of benefits described in subsection (p)(2)(A),

''(II) except for nominal copayments imposed for services covered under part B of this title, such benefits include at least the core group of basic benefits described in subsection (p)(2)(B), and

''(III) an enrollee's liability under such policy for physician's services covered under part B of this title is limited to the nominal copayments described in subclause (II),

the policy shall nevertheless be treated as meeting those requirements if the policy meets the requirements of subparagraph (B).

''(B) A policy meets the requirements of this subparagraph if—

''(i) full benefits are provided for items and services furnished through a network of entities which have entered into contracts or agreements with the issuer of the policy,

''(ii) full benefits are provided for items and services furnished by other entities if the services are medically necessary and immediately required because of an unforeseen illness, injury, or condition and it is not reasonable given the circumstances to obtain the services through the network,

''(iii) the network offers sufficient access,

''(iv) the issuer of the policy has arrangements for an ongoing quality assurance program for items and services furnished through the network,

''(v)(I) the issuer of the policy provides to each enrollee at the time of enrollment an explanation of—

''(aa) the restrictions on payment under the policy for services furnished other than by or through the network,

''(bb) out of area coverage under the policy,

''(cc) the policy's coverage of emergency services and urgently needed care, and

''(dd) the availability of a policy through the entity that meets the 1991 Model NAIC Regulation or 1991 Federal Regulation without regard to this subsection and the premium charged for such policy, and

''(II) each enrollee prior to enrollment acknowledges receipt of the explanation provided under subclause (I), and

''(vi) the issuer of the policy makes available to individuals, in addition to the policy described in this subsection, any policy (otherwise offered by the issuer to individuals in the State) that meets the 1991 Model NAIC Regulation or 1991 Federal Regulation and other requirements of this section without regard to this subsection.

''(C)(i) A policy described in this subparagraph—

''(I) is offered by an eligible organization (as defined in section 1876(b)),

''(II) is not a policy or plan providing benefits pursuant to a contract under section 1876 or an approved demonstration project described in section

603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, and

''(III) provides benefits which, when combined with benefits which are available under this title, are substantially similar to benefits under policies offered to individuals who are not entitled to benefits under this title.

''(ii) In making a determination under subclause (III) of clause (i) as to whether certain benefits are substantially similar, there shall not be taken into account, except in the case of preventive services, benefits provided under policies offered to individuals who are not entitled to benefits under this title which are in addition to the benefits covered by this title and which are benefits an entity must provide in order to meet the definition of an eligible organization under section 1876(b)(1).''.

(b) RENEWABILITY OF MEDICARE SELECT POLICIES.—Section 1882(q)(1) (42 U.S.C. 1395ss(q)(1)) is amended—

(1) by striking ''(1) Each'' and inserting ''(1)(A) Except as provided in subparagraph (B), each'';

(2) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively; and

(3) by adding at the end the following new subparagraph:

''(B)(i) In the case of a policy that meets the requirements of subsection (t), an issuer may cancel or nonrenew such policy with respect to an individual who leaves the service area of such policy; except that, if such individual moves to a geographic area where such issuer, or where an affiliate of such issuer, is issuing medicare supplemental policies, such individual must be permitted to enroll in any medicare supplemental policy offered by such issuer or affiliate that provides benefits comparable to or less than the benefits provided in the policy being canceled or nonrenewed. An individual whose coverage is canceled or nonrenewed under this subparagraph shall, as part of the notice of termination or nonrenewal, be notified of the right to enroll in other medicare supplemental policies offered by the issuer or its affiliates.

''(ii) For purposes of this subparagraph, the term 'affiliate' shall have the meaning given such term by the 1991 NAIC Model Regulation.''.

(c) CIVIL PENALTY.—Section 1882(t)(2) (42 U.S.C. 1395ss(t)(2)) is amended—

(1) by striking ''(2)'' and inserting ''(2)(A)'';

(2) by redesignating subparagraphs (A), (B), (C), and (D) as clauses (i), (ii), (iii), and (iv), respectively;

(3) in clause (iv), as redesignated—

(A) by striking ''paragraph (1)(E)(i)'' and inserting ''paragraph (1)(B)(v)(I); and

(B) by striking ''paragraph (1)(E)(ii)'' and inserting ''paragraph (1)(B)(v)(II)'';

(4) by striking ''the previous sentence'' and inserting ''this subparagraph''; and

(5) by adding at the end the following new subparagraph:

''(B) If the Secretary determines that an issuer of a policy approved under paragraph (1) has made a misrepresentation to the Secretary or has provided the Secretary with false information regarding such policy, the issuer is subject to a civil money penalty in an amount not to exceed $100,000 for each such determination. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this subparagraph

in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''.

(d) EFFECTIVE DATES.—

(1) NAIC STANDARDS.—If, within 9 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (hereafter in this subsection referred to as the ''NAIC'') makes changes in the 1991 NAIC Model Regulation (as defined in section 1882(p)(1)(A) of the Social Security Act) to incorporate the additional requirements imposed by the amendments made by this section, section 1882(g)(2)(A) of such Act shall be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed under this paragraph (such changed Regulation referred to in this subsection as the ''1995 NAIC Model Regulation'').

(2) SECRETARY STANDARDS.—If the NAIC does not make changes in the 1991 NAIC Model Regulation (as so defined) within the 9-month period specified in paragraph (1), the Secretary of Health and Human Services (hereafter in this subsection re-

ferred to as the ''Secretary'') shall promulgate a regulation and section 1882(g)(2)(A) of the Social Security Act shall be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed by the Secretary under this paragraph (such changed Regulation referred to in this subsection as the ''1995 Federal Regulation'').

(3) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State adopts the 1995 NAIC Model Regulation or the 1995 Federal Regulation, or

(ii) 1 year after the date the NAIC or the Secretary first adopts such regulations.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet the 1995 NAIC Model Regulation or the 1995 Federal Regulation, but

(ii) having a legislature which is not scheduled to meet in 1995 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1996. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

PART II—PROVISIONS RELATED TO PART A

SEC. 811. INPATIENT HOSPITAL SERVICES UPDATE FOR PPS HOSPITALS.

Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

(1) by amending subclause (XII) to read as follows:

''(XII) for fiscal years 1997 through 2000, the market basket percentage minus 1.0 percentage points for hospitals in all areas, and''; and

(2) in subclause (XIII), by striking ''1998'' and inserting ''2001''.

SEC. 812. REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS FOR INPATIENT HOSPITAL SERVICES.

(a) REDUCTION IN BASE PAYMENT RATES FOR PPS HOSPITALS.—Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended by adding at the end the following new sentence: ''In addition to the reduction described in the preceding sentence, for discharges occurring after September 30, 1995, the Secretary shall reduce by 7.31 percent the unadjusted standard Federal capital payment rate (as described in 42 CFR 412.308(c), as in effect on the date of the enactment of the America's Health Care Option Act) and shall reduce by 10.41 percent the unadjusted hospital-specific rate (as described in 42 CFR 412.328(e)(1), as in effect on the date of the enactment of the America's Health Care Option Act).''.

(b) REDUCTION IN PAYMENTS FOR PPS-EXEMPT HOSPITALS.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

''(T) Such regulations shall provide that, in determining the amount of the payments that may be made under this title with respect to the capital-related costs of inpatient hospital services furnished by a hospital that is not a subsection (d) hospital (as defined in section 1886(d)(1)(B)) or a subsection (d) Puerto Rico hospital (as defined in section 1886(d)(9)(A)), the Secretary shall reduce the amounts of such payments otherwise established under this title by 15 percent for payments attributable to portions of cost reporting periods occurring during each of the fiscal years 1996 through 2003.''.

SEC. 813. REVISIONS TO PAYMENT ADJUSTMENTS FOR DISPROPORTIONATE SHARE HOSPITALS IN PARTICIPATING STATES.

(a) APPLICATION OF ALTERNATIVE ADJUSTMENTS.—Section 1886(d)(5) (42 U.S.C. 1395ww(d)(5)) is amended—

(1) by redesignating subparagraphs (H) and (I) as subparagraphs (I) and (J); and

(2) by inserting after subparagraph (G) the following new subparagraph:

''(H)(i) In accordance with this subparagraph, the Secretary shall provide for an additional payment for each subsection (d) hospital that is located in a participating State under the America's Health Care Option Act during

a cost reporting period and that meets the eligibility requirements described in clause (iii).

''(ii) The amount of the additional payment made under clause (i) for each discharge shall be determined by multiplying—

''(I) the sum of the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and the amount paid to the hospital under subparagraph (A) for the discharge, by

''(II) the SSI adjustment percentage for the cost reporting period in which the discharge occurs (as defined in clause (iv)).

''(iii) A hospital meets the eligibility requirements described in this clause with respect to a cost reporting period if—

''(I) in the case of a hospital that is located in an urban area and that has more than 100 beds, the hospital's SSI patient percentage (as defined in clause (v)) for the cost reporting period is not less than 5.5 percent;

''(II) in the case of a hospital that is located in an urban area and that has less than 100 beds, the hospital's SSI patient percentage is not less than 17 percent;

''(III) in the case of a hospital that is classified as a rural referral center under subparagraph (C) or a sole community hospital under subparagraph (D), the hospital's SSI patient percentage for the cost reporting period is not less than 23 percent; and

''(IV) in the case of any other hospital, the hospital's SSI patient percentage is not less than 23 percent.

''(iv) For purposes of clause (ii), the 'SSI adjustment percentage' applicable to a hospital for a cost reporting period is equal to—

''(I) in the case of a hospital described in clause (iii)(I), the percentage determined in accordance with the following formula: e to the nth power − 1, where 'e' is the natural antilog of 1 and where 'n' is equal to (1.37 * (the hospital's SSI patient percentage for the cost reporting period − .055));

''(II) in the case of a hospital described in clause (iii)(II) or clause (iii)(IV), 2 percent; and

''(III) in the case of a hospital described in clause (iii)(III), the sum of 2 percent and .30 percent of the difference between the hospital's SSI patient percentage for the cost reporting period and 23 percent.

''(v) In this subparagraph, a hospital's 'SSI patient percentage' with respect to a cost reporting period is equal to the fraction (expressed as a percentage)—

''(I) the numerator of which is the number of the hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A and were entitled to supplementary security income benefits (excluding State supplementation) under title XVI; and

''(II) the denominator of which is the number of the hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A.''.

(b) NO STANDARDIZATION RESULTING FROM REDUCTION.—Section 1886(d)(2)(C)(iv) (42 U.S.C. 1395ww(d)(2)(C)(iv)) is amended—

(1) by striking ''exclude additional payments'' and inserting ''adjust such estimate for changes in payments'';

(2) by striking ''1989 or'' and inserting ''1989,''; and

(3) by striking the period at the end and inserting the following: '', or the enactment of section 813 of the America's Health Care Option Act.''.

(c) CONFORMING AMENDMENT.—Section 1886(d)(5)(F)(i) (42 U.S.C. 1395ww(d)(5)(F)(i)) is amended in the matter preceding subclause (I) by inserting after ''hospital'' the following: ''that is not located in a State that is a participating State under the America's Health Care Option Act''.

SEC. 814. MORATORIUM ON DESIGNATION OF NEW LONG-TERM HOSPITALS.

Effective October 1, 1994, notwithstanding clause (iv) of section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)), a hospital which has an average inpatient length of stay (as determined by the Secretary of Health and Human Services) of greater than 25 days shall not be treated as a hospital described in such clause for purposes of such title unless such hospital was treated as a hospital described in such clause for purposes of such title as of the date of the enactment of this Act.

SEC. 815. REDUCTION IN ADJUSTMENT FOR INDIRECT MEDICAL EDUCATION.

(a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended to read as follows:

''(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor is equal to c * (((1 + r) to the nth power) − 1), where 'r' is the ratio of the

hospital's full-time equivalent interns and residents to beds and 'n' equals .405. For discharges occurring on or after—

''(I) May 1, 1986, and before October 1, 1995, 'c' is equal to 1.89, and

''(II) October 1, 1995, 'c' is equal to 1.65.''.

(b) NO RESTANDARDIZATION OF PAYMENT AMOUNTS REQUIRED.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by striking ''of 1985'' and inserting ''of 1985, but not taking into account the amendments made by section 816(a) of the America's Health Care Option Act''.

SEC. 816. REDUCTION IN ROUTINE SERVICE COST LIMITS FOR SKILLED NURSING FACILITIES.

(a) PAYMENTS BASED ON COST LIMITS.—Section 1888(a) (42 U.S.C. 1395yy(a)) is amended by striking ''112 percent'' each place it appears and inserting ''106 percent (adjusted by such amount as the Secretary determines to be necessary to preserve the savings resulting from the enactment of section 13503(a)(1) of the Omnibus Budget Reconciliation Act of 1993)''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to cost reporting periods beginning on or after October 1, 1995.

PART III—PROVISIONS RELATING TO PART B

SEC. 821. UPDATES FOR PHYSICIANS' SERVICES.

Section 1848(d)(1) (42 U.S.C. 1395w–4(d)(1)) is amended—

(1) in subparagraph (A), by inserting after ''subparagraph (B)'' the following: ''and, in the case of 1995, specified in subparagraph (C)'';

(2) by redesignating subparagraph (C) as subparagraph (D); and

(3) by inserting after subparagraph (B) the following new subparagraph:

''(C) SPECIAL PROVISION FOR 1995.—For purposes of subparagraph (A), the conversion factor specified in this subparagraph for 1995 is in the case of physicians' services (not included in the category of primary care services (as defined for purposes of subsection (j)(1))), the conversion factor established under this subsection for 1994 reduced by 3 percent and adjusted by the update established under paragraph (3) for 1995.''.

SEC. 822. SUBSTITUTION OF REAL GDP TO ADJUST FOR VOLUME AND INTENSITY; REPEAL OF RESTRICTION ON MAXIMUM REDUCTION PERMITTED IN DEFAULT UPDATE.

(a) USE OF REAL GDP TO ADJUST FOR VOLUME AND INTENSITY.—Section 1848(f)(2)(A)(iii) (42 U.S.C. 1395w–4(f)(2)(A)(iii)) is amended to read as follows:

''(iii) 1 plus the average per capita growth in the real gross domestic product (divided by 100) for the 5-fiscal-year period ending with the previous fiscal year (increased by 1.5 percentage points for the category of services consisting of primary care services), and''.

(b) REPEAL OF RESTRICTION ON MAXIMUM REDUCTION.—Section 1848(d)(3)(B)(ii) (42 U.S.C. 1395w–4(d)(3)(B)(ii)) is amended—

(1) in the heading, by inserting ''IN CERTAIN YEARS'' after ''ADJUSTMENT'';

(2) in the matter preceding subclause (I), by striking ''for a year'';

(3) in subclause (I), by adding ''and'' at the end;

(4) in subclause (II), by striking '', and'' and inserting a period; and

(5) by striking subclause (III).

(c) REPEAL OF PERFORMANCE STANDARD FACTOR.—

(1) IN GENERAL.—Section 1848(f)(2) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

(2) CONFORMING AMENDMENT.—Section 1848(f)(2)(A) is amended in the matter following clause (iv) by striking ''1, multiplied by 100'' and all that follows through ''subparagraph (B))'' and inserting ''1 and multiplied by 100''.

(d) EFFECTIVE DATE.—

(1) VOLUME PERFORMANCE STANDARDS.—The amendments made by subsections (a) and (c) shall apply with respect to volume performance standards established beginning with fiscal year 1995.

(2) REPEAL OF RESTRICTION ON MAXIMUM REDUCTION.—The amendments made by subsection (b) shall apply to services furnished on or after January 1, 1997.

SEC. 823. ESTABLISHMENT OF CUMULATIVE EXPENDITURE GOALS FOR PHYSICIAN SERVICES.

(a) USE OF CUMULATIVE PERFORMANCE STANDARD.—Section 1848(f)(2) (42 U.S.C. 1395w–4(f)(2)) is amended—

(1) in subparagraph (A)—

(A) in the heading, by striking ''IN GENERAL'' and inserting ''FISCAL YEARS 1991 THROUGH 1994.—'',

(B) in the matter preceding clause (i), by striking ''a fiscal year (beginning with fiscal year 1991)'' and inserting ''fiscal years 1991, 1992, 1993, and 1994'', and

(C) in the matter following clause (iv), by striking ''subparagraph (B)'' and inserting ''subparagraph (C)'';

(2) in subparagraph (B), by striking ''subparagraph (A)'' and inserting ''subparagraphs (A) and (B)'';

(3) by redesignating subparagraphs (B) and (C) as subparagraphs (C) and (D); and

(4) by inserting after subparagraph (A) the following new subparagraph:

''(B) FISCAL YEARS BEGINNING WITH FISCAL YEAR 1995.—Unless Congress otherwise provides, the performance standard rate of increase, for all physicians' services and for each category of physicians' services, for a fiscal year beginning with fiscal year 1995 shall be equal to the performance standard rate of increase

determined under this paragraph for the previous fiscal year, increased by the product of—

''(i) 1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services or for the category of physicians' services, respectively, under this part for portions of calendar years included in the fiscal year involved,

''(ii) 1 plus the Secretary's estimate of the percentage increase or decrease (divided by 100) in the average number of individuals enrolled under this part (other than HMO enrollees) from the previous fiscal year to the fiscal year involved,

''(iii) 1 plus the Secretary's estimate of the average annual percentage growth (divided by 100) in volume and intensity of all physicians' services or of the category of physicians' services, respectively, under this part for the 5-fiscal-year period ending with the preceding fiscal year (based upon information contained in the most recent annual report made pursuant to section 1841(b)(2)), and

''(iv) 1 plus the Secretary's estimate of the percentage increase or decrease (divided by 100) in expenditures for all physicians' services or of the category of physicians' services, respectively, in the fiscal year (compared with the previous fiscal year) which are estimated to result from changes in law or regulations affecting the percentage increase described in clause (i) and which is not taken into account in the percentage increase described in clause (i), minus 1, multiplied by 100, and reduced by the performance standard factor (specified in subparagraph (C)).''.

(b) TREATMENT OF DEFAULT UPDATE.—

(1) IN GENERAL.—Section 1848(d)(3)(B) (42 U.S.C. 1395w–4(d)(3)(B)) is amended—

(A) in clause (i)—

(i) in the heading, by striking ''IN GENERAL'' and inserting ''1992 THROUGH 1996'', and

(ii) by striking ''for a year'' and inserting ''for 1992, 1993, 1994, 1995, and 1996''; and

(B) by adding after clause (ii) the following new clause:

''(iii) YEARS BEGINNING WITH 1997.—

''(I) IN GENERAL.—The update for a category of physicians' services for a year beginning with 1997 provided under subparagraph (A) shall be increased or decreased by the same percentage by which the cumulative percentage increase in actual expenditures for such category of physicians' services for such year was less or greater, respectively, than the performance standard rate of increase (established under subsection (f)) for such category of services for such year.

''(II) CUMULATIVE PERCENTAGE INCREASE DEFINED.—In subclause (I), the 'cumulative percentage increase in actual expenditures' for a year shall be equal to the product of the adjusted increases for each year beginning with 1995 up to and including the year involved, minus 1 and

multiplied by 100. In the previous sentence, the 'adjusted increase' for a year is equal to 1 plus the percentage increase in actual expenditures for the year.''.

(2) CONFORMING AMENDMENT.—Section 1848(d)(3)(A)(i) (42 U.S.C. 1395w–4(d)(3)(A)(i)) is amended by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (C)''.

SEC. 824. ESTABLISHMENT OF HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENTS.

(a) IN GENERAL.—Section 1833(a)(2)(B) of the Social Security Act (42 U.S.C. 1395l(a)(2)(B)) is amended by striking ''section 1886)—'' and all that follows and inserting the following: ''section 1886), an amount equal to a prospectively determined payment rate established by the Secretary that provides for payments for such items and services to be based upon a national rate adjusted to take into account the relative costs of furnishing such items and services in various geographic areas, except that for items and services furnished during cost reporting periods (or portions thereof) beginning on or after January 1, 1995, such amount shall not exceed 90 percent of the amount that would otherwise have been determined under

this subparagraph had the amendment made by section 824(a) of the America's Health Care Option Act had not taken effect;''.

(b) ESTABLISHMENT OF PROSPECTIVE PAYMENT SYSTEM.—Not later than January 1, 1995, the Secretary of Health and Human Services shall establish the prospective payment system for hospital outpatient services necessary to carry out section 1833(a)(2)(B) of the Social Security Act (as amended by subsection (a)). Such prospective payment system shall provide that an individual have a cost-sharing requirement of 20 percent of the allowable amount on which the prospectively determined rate for such service is based.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items and services furnished on or after January 1, 1995.

SEC. 825. GENERAL PART B PREMIUM.

Section 1839(e) (42 U.S.C. 1395r(e)) is amended—

(1) in paragraph (1)(A), by striking ''and prior to January 1999''; and

(2) in paragraph (2), by striking ''prior to January 1998''.

PART IV—PROVISIONS RELATED TO PARTS A AND B

SEC. 831. MEDICARE SECONDARY PAYER CHANGES.

(a) EXTENSION OF DATA MATCH.—

(1) Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

(b) REPEAL OF SUNSET ON APPLICATION TO DISABLED EMPLOYEES OF EMPLOYERS WITH MORE THAN 100 EMPLOYEES.—Section 1862(b)(1)(B)(iii) (42 U.S.C. 1395y(b)(1)(B)(iii)) is amended—

(1) in the heading, by striking ''SUNSET'' and inserting ''EFFECTIVE DATE''; and

(2) by striking '', and before October 1, 1998''.

(c) EXTENSION OF PERIOD FOR END STAGE RENAL DISEASE BENEFICIARIES.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended in the second sentence by striking ''and on or before October 1, 1998,''.

SEC. 832. INCREASE IN MEDICARE SECONDARY PAYER COVERAGE FOR END STAGE RENAL DISEASE SERVICES TO 24 MONTHS.

(a) IN GENERAL.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)), as amended by section 831(c), is amended by striking the last sentence and inserting: ''Effective

for items and services furnished on or after January 1, 1996 (with respect to periods beginning on or after July 1, 1994), this subparagraph shall be applied by substituting '24-month' for '12-month' each place it appears.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items and services provided on or after January 1, 1996.

SEC. 833. REDUCTION IN ROUTINE COST LIMITS FOR HOME HEALTH SERVICES.

Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amended—

(1) in subclause (II), by striking ''or'' at the end;

(2) in subclause (III), by striking ''112 percent,'' and inserting ''and before July 1, 1996, 112 percent, or''; and

(3) by inserting after subclause (III) the following new subclause:

''(IV) July 1, 1996, 106 percent (adjusted by such amount as the Secretary determines to be necessary to preserve the savings resulting from the enactment of section 13564(a)(1) of the Omnibus Budget Reconciliation Act of 1993),''.

Subtitle B—Medicaid Program

PART I—COORDINATION OF THE MEDICAID PROGRAM WITH REFORMED HEALTH CARE SYSTEM

SEC. 851. STATE PLAN REQUIREMENT REGARDING ELIGIBILITY FOR MEDICAL ASSISTANCE.

(a) IN GENERAL.—Section 1902(a) (42 U.S.C. 1369a(a)), as amended by sections 121 and 201(a), is amended—

(1) by striking ''and'' at the end of paragraph (63);

(2) by striking the period at the end of paragraph (64) and inserting ''; and ''; and

(3) by adding at the end the following new paragraph:

''(65) provide that the State will continue to make eligible for medical assistance under section 1902(a)(10) any class or category of individuals eligible for medical assistance under such section as of the date of the enactment of the America's Health Care Option Act.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall be effective with respect to calendar quarters beginning on or after the date of the enactment of this Act.

SEC. 852. CAP ON PAYMENTS MADE FOR CERTAIN ACUTE MEDICAL SERVICES FURNISHED UNDER THE MEDICAID PROGRAM.

(a) IN GENERAL.—Title XIX (42 U.S.C. 1396 et seq.) is amended by redesignating section 1931 as section 1932 and by inserting after section 1930 the following new section:

''CAP ON PAYMENTS MADE FOR CERTAIN ACUTE MEDICAL SERVICES

''SEC. 1931. (a) FEDERAL CAP.—

''(1) IN GENERAL.—Notwithstanding any provision of this part, the amount of any payment to a State under section 1903(a)(1) with respect to expenditures made by a State for furnishing acute medical services (as defined in subsection (c)(1)) of the type included in the FedMed benefits package (as described in section 21115(b)) to integration eligible individuals (as defined in subsection (c)(2)) in any calendar quarter shall not be in excess of the amount determined under paragraph (2) for the quarter.

''(2) AMOUNT DETERMINED.—The amount determined under this paragraph for a quarter is an amount equal to ¼ of the product of—

''(A) the State's Federal medical assistance percentage (as defined in section 1905(b))

of the weighted average maximum premium subsidy amount (as defined in subsection (c)(4)) for the State for the year; multiplied by

''(B) the average number of integration eligible individuals receiving medical assistance under the State plan consisting of acute medical services of the type included in the FedMed benefits package in any month in the quarter.

''(b) STATE CAP.—

''(1) IN GENERAL.—Notwithstanding any provision of this part, a State shall not be obligated to expend an amount in excess of the amount determined under paragraph (2) in any calendar quarter for furnishing acute medical services of the type included in the FedMed benefits package to integration eligible individuals.

''(2) AMOUNT DETERMINED.—The amount determined under this paragraph for a quarter is an amount equal to ¼ of the product of—

''(A) the State matching percentage (as defined in subsection (a)(3)) of weighted average maximum premium subsidy amount for the State for the year; multiplied by

''(B) the average number of integration eligible individuals receiving medical assistance

under the State plan consisting of acute medical services of the type included in the FedMed benefits package in any month in the quarter.

''(c) DEFINITIONS.—

''(1) ACUTE MEDICAL SERVICES.—The term 'acute medical services' means items and services described in section 1905(a) other than the following:

''(A) Nursing facility services (as defined in section 1905(f)).

''(B) Intermediate care facility for the mentally retarded services (as defined in section 1905(d)).

''(C) Personal care services (as described in section 1905(a)(24)).

''(D) Private duty nursing services (as referred to in section 1905(a)(8)).

''(E) Home or community-based services furnished under a waiver granted under subsection (c), (d), or (e) of section 1915.

''(F) Home and community care furnished to functionally disabled elderly individuals under section 1929.

''(G) Community supported living arrangements services under section 1930.

''(H) Case-management services (as described in section 1915(g)(2)).

''(I) Home health care services (as referred to in section 1905(a)(7)), clinic services, and rehabilitation services that are furnished to an individual who has a condition or disability that qualifies the individual to receive any of the services described in a previous subparagraph.

''(J) Services furnished in an institution for mental diseases (as defined in section 1905(i)).

''(2) INTEGRATION ELIGIBLE INDIVIDUAL.—The term 'integration eligible individual' means, with respect to any calendar quarter, an individual who would not be eligible for medical assistance consisting of acute medical services of the type included in the FedMed benefits package if the provisions of section 1932(a) were in effect during such quarter.

''(3) STATE MATCHING PERCENTAGE.—The term 'State matching percentage' means, with respect to a State, the amount (expressed as a percentage) equal to 1 minus the State's Federal medical assistance percentage.

''(4) WEIGHTED AVERAGE MAXIMUM PREMIUM SUBSIDY AMOUNT.—

''(A) IN GENERAL.—The term 'weighted average maximum premium subsidy amount' for a State for a year means an amount equal to—

''(i) the sum of—

''(I) the amount determined under subparagraph (B) for each community-rating area in the State; multiplied by

''(II) the number of individuals in such community rating area; divided by

''(ii) the total number of individuals in the State.

''(B) WEIGHTED AVERAGE MAXIMUM SUBSIDY AMOUNT IN A COMMUNITY-RATING AREA.—The weighted average maximum subsidy amount in a community-rating area is an amount equal to—

''(i) the sum of—

''(I) the weighted average age adjusted maximum subsidy amount for an enrollment class (as determined under subparagraph (C)) in the community-rating area; multiplied by

''(II) the number of individuals in the enrollment class in the community-rating area; divided by

''(ii) the total number of individuals in the community-rating area.

''(C) WEIGHTED AVERAGE AGE ADJUSTED MAXIMUM SUBSIDY AMOUNT FOR AN ENROLLMENT CLASS.—The weighted average age adjusted maximum subsidy amount for an enrollment class is an amount equal to—

''(i) the sum of—

''(I) the age adjusted maximum subsidy amount determined under section 1952(b)(2)) for each category of primary insurer in the enrollment class; multiplied by

''(II) the number of individuals in each category; divided by

''(ii) the total number of individuals in all such categories.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall be effective with respect to calendar quarters beginning on or after January 1, 1997.

SEC. 853. INTEGRATION OF CERTAIN MEDICAID ELIGIBLES INTO REFORMED HEALTH CARE SYSTEM THROUGH STATE PREMIUM ASSISTANCE PROGRAM.

(a) IN GENERAL.—Title XIX (42 U.S.C. 1396 et seq.), as amended by section 852, is amended by redesignating section 1932 as section 1933 and by inserting after section 1931 the following new section:

''INTEGRATION OF CERTAIN MEDICAID ELIGIBLES INTO REFORMED HEALTH CARE SYSTEM

''SEC. 1932. (a) IN GENERAL.—

''(1) REQUIREMENT ON STATES.—With respect to calendar quarters beginning on or after January 1, 2000, a State with a State plan under this part—

''(A) shall not furnish medical assistance consisting of acute medical services described in section 1931(b)(1) to any individuals not described in subsection (b) who are otherwise eligible for medical assistance under the plan; and

''(B) shall integrate such individuals into the State's premium assistance program under part B.

''(2) STATE OPTION.—

''(A) IN GENERAL.—For 1997, 1998, and 1999, a State may elect to integrate individuals into the State's premium assistance program

under part B as described in paragraph (1) if the State notifies the Secretary of such election not later than October 1 of the year preceding the year the State intends to begin such integration.

''(B) STATES FURNISHING SERVICES UNDER A WAIVER.—If a State making an election under subparagraph (A) is furnishing medical assistance consisting of acute medical services described in section 1931(b)(1) under a waiver under section 1115 granted on or before December 31, 1996, to individuals who would otherwise be integrated into the State's premium assistance program, such State may continue to furnish such services to such individuals until the earlier of the termination of the waiver by the State or the Secretary or January 1, 2000.

''(b) INDIVIDUALS DESCRIBED.—The individuals described in this subsection are—

''(1) SSI-eligible individuals (as defined in section 1933(d)(2));

''(2) individuals who are eligible for benefits under part A of title XVIII; and

''(3) certain aliens with respect to whom emergency services are furnished under section 1903(v)(2).

''(c) STATE MAINTENANCE OF EFFORT.—

''(1) IN GENERAL.—

''(A) REDUCTION IN QUARTERLY PAYMENTS.—For any calendar quarter in an integration year (as defined in subparagraph (B)), the amount otherwise payable to a State under section 1903 for the quarter shall be reduced by the State maintenance of effort amount for the quarter determined under paragraph (2).

''(B) INTEGRATION YEAR.—For purposes of this paragraph, the term 'integration year' means the first year that the State integrates individuals into the State's premium assistance program under part B and any succeeding year.

''(2) MAINTENANCE OF EFFORT AMOUNT.—

''(A) IN GENERAL.—The maintenance of effort amount for a State for a calendar quarter in an integration year shall be equal to 25 percent of the State's base payment amount (determined under subparagraph (B)) updated by the percentage change in the inflation index described in subparagraph (C)(i) and the State

population index described in subparagraph (C)(ii) during the period beginning on January 1 of the first integration year and ending on December 31 of the applicable integration year (as determined by the Secretary).

''(B) STATE BASE PAYMENT AMOUNT.—The base payment amount for a State for an integration year shall be an amount, as determined by the Secretary, equal to the total expenditures from State funds made under the State plan during the year preceding the first integration year with respect to medical assistance consisting of acute medical services of the type included in the FedMed benefits package (as described in section 21115(b)) furnished to individuals who would not have received such assistance if the provisions of subsection (a) were in effect during such year.

''(C) INDEXES DESCRIBED.—

''(i) INFLATION INDEX.—The Secretary shall establish an index which measures the percentage change in the weighted average maximum premium subsidy amount (as defined in section 1931(c)(4)) for the State from year to year.

''(ii) STATE POPULATION INDEX.—The Secretary shall establish a State population index which measures the change in the number of individuals residing in a State from year to year.''

(b) NO FEDERAL FINANCIAL PARTICIPATION.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended—

(1) by striking ''or'' at the end of paragraph (14),

(2) by striking the period at the end of paragraph (15) and inserting ''; or'', and

(3) by inserting after paragraph (15) the following new paragraph:

''(16) with respect any medical assistance consisting of acute medical services described in section 1931(b) furnished to individuals who are not described in section 1932(b).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall be effective with respect calendar quarters beginning on or after January 1, 1997.

SEC. 854. STATE PROGRAMS FOR PROVIDING SUPPLEMENTAL BENEFITS.

(a) MEDICAID STATE PLAN REQUIREMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)),

as amended by sections 121, 201(a), and 851, is amended—

(1) by striking ''and'' at the end of paragraph (64);

(2) by striking the period at the end of paragraph (65) and inserting ''; and''; and

(3) by adding at the end the following new paragraph:

''(66) provide for a State program furnishing supplemental benefits in accordance with part C.''.

(b) STATE PROGRAMS FOR SUPPLEMENTAL BENEFITS.—Title XIX (42 U.S.C. 1396 et seq.), as amended by section 121, is amended by adding at the end the following new part:

''PART C—STATE PROGRAMS FOR SUPPLEMENTAL BENEFITS

''SEC. 1961. REQUIREMENT TO OPERATE STATE PROGRAM.

''(a) IN GENERAL.—A State with a State plan approved under part A shall have in effect a program for furnishing supplemental benefits (as defined in section 1962(c)) in accordance with this part in calendar years beginning after 1996.

''(b) DESIGNATION OF STATE AGENCY.—A State may designate any appropriate State agency to administer the program under this part.

"SEC. 1962. PROGRAM DESCRIBED.

''(a) IN GENERAL.—A State program under this part shall furnish supplemental benefits to such classes and categories of the individuals eligible for premium assistance under part B as determined appropriate by the State.

''(b) PRIORITIES.—A State may give priority to children, pregnant women, and individuals residing in medically underserved areas in furnishing services under this part.

''(c) SUPPLEMENTAL BENEFITS DEFINED.—The term 'supplemental benefits' means the acute medical services described in section 1931(b) that—

''(1) were furnished under the State plan in the year preceding the first year that the State integrates individuals into the State's premium assistance program under part B in accordance with section 1932(a); and

''(2) are not included in the items and services provided under the FedMed benefits package (as described in 21115(b)).

"SEC. 1963. PAYMENTS TO STATES.

''From its allotment under section 1964(b), the Secretary shall pay to each State for each quarter beginning with the quarter commencing January 1, 1997, an amount equal to—

''(1) an amount equal to the State's Federal medical assistance percentage (as defined in section 1905(b)) of the amount demonstrated by State claims to have been expended during the quarter for furnishing services to eligible individuals under this part; plus

''(2) an amount equal to 50 percent of the remainder of the amounts expended during the quarter as found necessary by the Secretary for the proper and efficient administration of the State program.

''SEC. 1964. FUNDING.

''(a) IN GENERAL.—The total amount of Federal funds available for State programs under this part for each fiscal year is—

''(1) for fiscal year 1997, $12,000,000,000; and

''(2) for succeeding fiscal years, the amount determined under this subsection for the preceding fiscal year updated by the estimated percentage change in the inflation index described in section 1932(c)(2)(C)(i) and the State population index described in secton 1932(c)(2)(C)(ii).

''(b) ALLOTMENTS TO STATES.—

''(1) IN GENERAL.—The Secretary shall allot the amounts available under subsection (a) for the fiscal year to the States in accordance with an allo-

cation formula developed by the Secretary which takes into account—

''(A) the percentage of all individuals with incomes at or below 150 percent of the official poverty line (as defined in section 1957(6)) in all States that reside in a particular State; and

''(B) a State's matching percentage (as defined in section 1932(c)(4)(B)).

''(2) REALLOCATIONS.—Any amounts allotted to States under this subsection for a year that are not expended in such year shall remain available for State programs under this part and may be reallocated to States as the Secretary determines appropriate.

''(c) STATE ENTITLEMENT.—This part constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Government to provide for the payment to States of amounts described in subsection (a).''.

(c) CONFORMING AMENDMENTS.—Title XIX (42 U.S.C. 1396 et seq.), as amended by section 121, is amended by striking the title and inserting the following:

"TITLE XIX—MEDICAL ASSISTANCE PROGRAMS, STATE PROGRAMS FOR PREMIUM ASSISTANCE, AND STATE PROGRAMS FOR SUPPLEMENTAL BENEFITS".

SEC. 855. OPTIONAL COVERAGE UNDER CERTIFIED HEALTH PLANS OF SSI-ELIGIBLE INDIVIDUALS.

(a) STATE OPTION.—Section 1902(a) (42 U.S.C. 1396a(a)), as amended by sections 121, 201(a), 851, and 854, is amended—

(1) by striking ''and'' at the end of paragraph (65);

(2) by striking the period at the end of paragraph (66) and inserting ''; and''; and

(3) by adding at the end the following new paragraph:

''(67) at the option of the State, provide that a SSI-eligible individual (as defined in section 1933(d)) has the option to receive medical assistance consisting of the items or services covered under the FedMed benefits package (as described in section 21115(b)) through enrollment with a certified health plan (as defined in 21003(b)) providing such pack-

age instead of through enrollment in the State plan, in accordance with the requirements of section 1933.''.

(b) REQUIREMENTS DESCRIBED.—Title XIX (42 U.S.C. 1396 et seq.) is amended by redesignating section 1933 as section 1934 and by inserting after section 1932 the following new section:

''REQUIREMENTS FOR STATES PROVIDING OPTIONAL COVERAGE UNDER CERTIFIED HEALTH PLANS TO SSI-ELIGIBLE INDIVIDUALS

''SEC. 1933. (a) IN GENERAL.—For purposes of section 1902(a)(67), a State meets the requirements of this section with respect to SSI-eligible individuals if the State meets the following requirements:

''(1) CHOICE OF PLANS.—The State must offer individuals a choice of a certified health plans under such section, except that nothing in this paragraph may be construed to waive any limits on the capacity of a certified health plan applicable under title XXI.

''(2) INFORMED CHOICE.—The State shall ensure that each SSI-eligible individual is provided sufficient information to make an informed choice about enrolling in a certified health plan under such section and selecting such a plan.

''(3) PAYMENTS TO CERTIFIED HEALTH PLANS BY STATES.—The State shall make all necessary

payments of premiums, copayments, and deductibles applicable under a certified health plan on behalf of a SSI-eligible individual who enrolls in a certified health plan under such section.

''(b) TREATMENT OF PAYMENTS AS MEDICAL ASSISTANCE.—For purposes of determining the amount of Federal financial participation for a State under section 1903 in a quarter, any payments made by a State under subsection (a)(3) shall be treated as expenditures for medical assistance under the State plan for such quarter.

''(c) LIMITATION ON NUMBER OF INDIVIDUALS PERMITTED TO MAKE ELECTION.—

''(1) IN GENERAL.—

''(A) LIMITATION.—The number of SSI-eligible individuals electing to enroll in a certified health plan under section 1902(a)(67) in a State during a year may not exceed the applicable percentage determined under subparagraph (B) of the Secretary's estimate of the number of such individuals in the State who are eligible to enroll in certified health plans under such section during the year.

''(B) APPLICABLE PERCENTAGE DESCRIBED.—The 'applicable percentage' deter-

mined under this subparagraph with respect to a State for a year—

''(i) for each of the first 3 years for which the State exercises the option described in such section, 15 percent; and

''(ii) for each succeeding year for which the State exercises such option, the applicable percentage under this subparagraph for the preceding year, increased by 10 percent.

''(2) WAIVER OF LIMITATION.—The limit on the number of individuals provided in paragraph (1) may be waived by the Secretary with respect to a State if the Secretary determines that such a waiver is appropriate.

''(d) DEFINITIONS.—

''(1) CERTIFIED HEALTH PLAN.—The term 'certified health plan' means a certified health plan (as defined in section 21003(b)) that provides a FedMed benefits package (as described in section 21115(b)).

''(2) SSI-ELIGIBLE INDIVIDUAL.—The term 'SSI-eligible individual' means an individual who is eligible for medical assistance under the State plan and—

''(A) with respect to whom supplemental security income benefits are being paid under title XVI,

''(B) who is receiving a supplementary payment under section 1616 or under section 212 of Public Law 93–66, or

''(C) who is receiving monthly benefits under section 1619(a) (whether or not pursuant to section 1616(c)(3)).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall be effective with respect to calendar quarters beginning on or after January 1, 1997.

PART II—STATE ELIGIBILITY TO CONTRACT FOR COORDINATED CARE SERVICES

SEC. 861. MODIFICATION OF FEDERAL REQUIREMENTS TO ALLOW STATES MORE FLEXIBILITY IN CONTRACTING FOR COORDINATED CARE SERVICES UNDER MEDICAID.

(a) IN GENERAL.—

(1) PAYMENT PROVISIONS.—Section 1903(m) (42 U.S.C. 1396b(m)) is amended to read as follows:

''(m)(1) No payment shall be made under this title to a State with respect to expenditures incurred by such State for payment to an entity which is at risk (as defined in section 1931(a)(4)) for services provided by such entity

to individuals eligible for medical assistance under the State plan under this title, unless the entity is a risk contracting entity (as defined in section 1931(a)(3)) and the State and such entity comply with the applicable provisions of section 1931.

''(2) No payment shall be made under this title to a State with respect to expenditures incurred by such State for payment for services provided to an individual eligible for medical assistance under the State plan under this title if such payment by the State is contingent upon the individual receiving such services from a specified health care provider or subject to the approval of a specified health care provider, unless the entity receiving payment is a primary care case management entity (as defined in section 1931(a)(2)) and the State and such entity comply with the applicable provisions of section 1931.''.

(2) REQUIREMENTS FOR COORDINATED CARE SERVICES.—Title XIX (42 U.S.C. 1396 et seq.) is amended by adding at the end the following new section:

''REQUIREMENTS FOR COORDINATED CARE SERVICES

''SEC. 1931. (a) DEFINITIONS.—For purposes of this title—

''(1) PRIMARY CARE CASE MANAGEMENT PROGRAM.—The term 'primary care case management program' means a program operated by a State

agency under which such State agency enters into contracts with primary care case management entities for the provision of health care items and services which are specified in such contracts and the provision of case management services to individuals who are—

''(A) eligible for medical assistance under the State plan,

''(B) enrolled with such primary care case management entities, and

''(C) entitled to receive such specified health care items and services and case management services only as approved and arranged for, or provided, by such entities.

''(2) PRIMARY CARE CASE MANAGEMENT ENTITY.—The term 'primary care case management entity' means a health care provider which—

''(A) must be a physician, group of physicians, a Federally qualified health center, a rural health clinic, or an entity employing or having other arrangements with physicians operating under a contract with a State to provide services under a primary care case management program,

''(B) receives payment on a fee for service basis (or, in the case of a Federally qualified health center or a rural health clinic, on a reasonable cost per encounter basis) for the provision of health care items and services specified in such contract to enrolled individuals,

''(C) receives an additional fixed fee per enrollee for a period specified in such contract for providing case management services (including approving and arranging for the provision of health care items and services specified in such contract on a referral basis) to enrolled individuals, and

''(D) is not an entity that is at risk (as defined in paragraph (4)) for such case management services.

''(3) RISK CONTRACTING ENTITY.—The term 'risk contracting entity' means an entity, including a certified health plan (as defined in section 21003(b)) that provides a FedMed benefits package (as described in section 21115(b)), which has a contract with the State agency (or a health insuring organization described in subsection (l)(2)) under which the entity—

''(A) provides or arranges for the provision of health care items or services which are specified in such contract to individuals eligible for medical assistance under the State plan, and

''(B) is at risk (as defined in paragraph (4)) for part or all of the cost of such items or services furnished to individuals eligible for medical assistance under such plan.

''(4) AT RISK.—The term 'at risk' means an entity which—

''(A) has a contract with the State agency under which such entity is paid a fixed amount for providing or arranging for the provision of health care items or services specified in such contract to an individual eligible for medical assistance under the State plan and enrolled with such entity, regardless of whether such items or services are furnished to such individual, and

''(B) is liable for all or part of the cost of furnishing such items or services, regardless of whether such cost exceeds such fixed payment.

''(5) FEDERALLY QUALIFIED HEALTH CENTER.—The term 'Federally qualified health center' means a Federally qualified health center as defined in section 1905(l)(2)(B).

''(6) RURAL HEALTH CLINIC.—The term 'rural health clinic' means a rural health clinic as defined in section 1905(l)(1).

''(b) GENERAL REQUIREMENTS FOR RISK CONTRACTING ENTITIES.—

''(1) ORGANIZATION.—A risk contracting entity meets the requirements of this section only if such entity—

''(A)(i) is a qualified health maintenance organization as defined in section 1310(d) of the Public Health Service Act, as determined by the Secretary pursuant to section 1312 of such Act; or

''(ii) is described in subparagraph (C), (D), (E), (F), or (G) of subsection (e)(4);

''(B) is a Federally qualified health center or a rural health clinic which has made adequate provision against the risk of insolvency (pursuant to the guidelines and regulations issued by the Secretary under this section), and ensures that individuals eligible for medical assistance under the State plan are not held liable for such entity's debts in case of such entity's insolvency; or

''(C) is an entity which meets all applicable State licensing requirements and has made adequate provision against the risk of insolvency (pursuant to the guidelines and regulations issued by the Secretary under this section), and ensures that individuals eligible for medical assistance under the State plan are not held liable for such entity's debts in case of such entity's insolvency.

''(2) GUARANTEES OF ENROLLEE ACCESS.—A risk contracting entity meets the requirements of this section only if—

''(A) the geographic locations, hours of operation, patient to staff ratios, and other relevant characteristics of such entity are sufficient to afford individuals eligible for medical assistance under the State plan access to such entities that is at least equivalent to the access to health care providers that would be available to such individuals if such individuals were not enrolled with such entity;

''(B) such entity has reasonable and adequate hours of operation, including 24-hour availability of—

''(i)(I) treatment for an unforeseen illness, injury, or condition of an individual eligible for medical assistance under the State plan and enrolled with such entity; or

''(II) referral to other health care providers for such treatment; and

''(ii) other information, as determined by the Secretary or the State; and

''(C) such entity complies with such other requirements relating to access to care as the Secretary or the State may impose.

''(3) CONTRACT WITH STATE AGENCY.—A risk contracting entity meets the requirements of this section only if such entity has a written contract with the State agency which provides—

''(A) that the entity will comply with all applicable provisions of this section, that the State has the right to penalize the entity for failure to comply with such requirements and to terminate the contract in accordance with subsection (i), and that the entity will be subject to penalties imposed by the Secretary under subsection (h) for failure to comply with such requirements;

''(B) for a payment methodology based on experience rating or another actuarially sound methodology approved by the Secretary, which guarantees (as demonstrated by such models or formulas as the Secretary may approve) that—

''(i) payments to the entity under the contract shall not exceed an amount equal to 100 percent of the costs (which shall include administrative costs and which may include costs for inpatient hospital services that would have been incurred in the absence of such contract) that would have been incurred by the State agency in the absence of the contract; and

''(ii) the financial risk for inpatient hospital services is limited to an extent established by the State;

''(C) that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect any books and records of the entity (and of any subcontractor) that pertain—

''(i) to the ability of the entity (or a subcontractor) to bear the risk of potential financial losses; or

''(ii) to services performed or determinations of amounts payable under the contract;

''(D) that in the entity's enrollment, reenrollment, or disenrollment of individuals eligible for medical assistance under the State plan and eligible to enroll, reenroll, or disenroll with the entity pursuant to the contract, the entity will not discriminate among such individuals on the basis of such individuals' health status or requirements for health care services;

''(E)(i) individuals eligible for medical assistance under the State plan who have enrolled with the entity are permitted to terminate such enrollment without cause as of the beginning of the first calendar month (or in the case of an entity described in subsection (e)(4), as of the beginning of the first enrollment period) following a full calendar month after a request is made for such termination;

''(ii) that when an individual has relocated outside the entity's service area, and the entity has been notified of the relocation, services (within reasonable limits) furnished by a health care provider outside the service area will be re-

imbursed either by the entity or by the State agency; and

''(iii) for written notification of each such individual's right to terminate enrollment, which shall be provided at the time of such individual's enrollment;

''(F) in the case of services immediately required to treat an unforeseen illness, injury, or condition, of an individual eligible for medical assistance under the State plan and enrolled with the entity—

''(i) that such services shall not be subject to a preapproval requirement; and

''(ii) where such services are furnished by a health care provider other than the entity, for reimbursement of such provider either by the entity or by the State agency;

''(G) for disclosure of information in accordance with subsection (g) and section 1124;

''(H) that any physician incentive plan operated by the entity meets the requirements of section 1876(i)(8);

''(I) for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients;

''(J) that the entity will comply with the requirement of section 1902(w) with respect to each enrollee;

''(K) that the entity will implement a grievance system, inform enrollees in writing about how to use such grievance system, ensure that grievances are addressed in a timely manner, and report grievances to the State at intervals to be determined by the State;

''(L) that contracts between the entity and each subcontractor of such entity will require each subcontractor—

''(i) to cooperate with the entity in the implementation of its internal quality assurance program under paragraph (4) and adhere to the standards set forth in the quality assurance program, including standards with respect to access to care, facilities in which patients receive care, and availability, maintenance, and review of medical records;

''(ii) to cooperate with the Secretary, the State agency and any contractor to the State in monitoring and evaluating the quality and appropriateness of care pro-

vided to enrollees as required by Federal or State laws and regulations; and

''(iii) where applicable, to adhere to regulations and program guidance with respect to reporting requirements under section 1905(r);

''(M) that, where the State deems it necessary to ensure the timely provision to enrollees of the services listed in subsection (f)(2)(C)(ii), the State may arrange for the provision of such services by health care providers other than the entity and may adjust its payments to the entity accordingly;

''(N) that the entity and the State will comply with guidelines and regulations issued by the Secretary with respect to procedures for marketing and information that must be provided to individuals eligible for medical assistance under the State plan;

''(O) that the entity shall report to the State, at such time and in such manner as the State shall require, on the rates paid for hospital services (by type of hospital and type of service) furnished to individuals enrolled with the entity;

''(P) detailed information regarding the relative responsibilities of the entity and the State, for providing (or arranging for the provision of), and making payment for, the following items and services:

''(i) immunizations;

''(ii) the purchase of vaccines;

''(iii) lead screening and treatment services;

''(iv) screening and treatment for tuberculosis;

''(v) screening and treatment for, and preventive services related to, sexually transmitted diseases, including HIV infection;

''(vi) screening, diagnostic, and treatment services required under section 1905(r);

''(vii) family planning services;

''(viii) services prescribed under—

''(I) an Individual Education Plan or Individualized Family Service Plan under part B or part H of the Individuals with Disabilities Education Act; and

''(II) any other individual plan of care or treatment developed under this title or title V;

''(ix) transportation needed to obtain services to which the enrollee is entitled under the State plan or pursuant to an individual plan of care or treatment described in subclauses (I) and (II) of clause (viii); and

''(x) such other services as the Secretary may specify;

''(Q) detailed information regarding the procedures for coordinating the relative responsibilities of the entity and the State to ensure prompt delivery of, compliance with any applicable reporting requirements related to, and appropriate recordkeeping with respect to, the items and services described in subparagraph (P); and

''(R) such other provisions as the Secretary may require.

''(4) INTERNAL QUALITY ASSURANCE.—A risk contracting entity meets the requirements of this section only if such entity has in effect a written internal quality assurance program which includes a

systematic process to achieve specified and measurable goals and objectives for access to, and quality of, care, which—

''(A) identifies the organizational units responsible for performing specific quality assurance functions, and ensures that such units are accountable to the governing body of the entity and that such units have adequate supervision, staff, and other necessary resources to perform these functions effectively,

''(B) if any quality assurance functions are delegated to other entities, ensures that the risk contracting entity remains accountable for all quality assurance functions and has mechanisms to ensure that all quality assurance activities are carried out,

''(C) includes methods to ensure that physicians and other health care professionals under contract with the entity are licensed or certified as required by State law, or are otherwise qualified to perform the services such physicians and other professionals provide, and that these qualifications are ensured through appropriate credentialing and recredentialing procedures,

''(D) provides for continuous monitoring of the delivery of health care, through—

''(i) identification of clinical areas to be monitored, including immunizations, prenatal care, services required under section 1905(r), and other appropriate clinical areas, to reflect care provided to enrollees eligible for medical assistance under the State plan,

''(ii) use of quality indicators and standards for assessing the quality and appropriateness of care delivered, and the availability and accessibility of all services for which the entity is responsible under such entity's contract with the State,

''(iii) use of epidemiological data or chart review, as appropriate, and patterns of care overall,

''(iv) patient surveys, spot checks, or other appropriate methods to determine whether—

''(I) enrollees are able to obtain timely appointments with primary care providers and specialists, and

''(II) enrollees are otherwise guaranteed access and care as provided under paragraph (2),

''(v) provision of written information to health care providers and other personnel on the outcomes, quality, availability, accessibility, and appropriateness of care, and

''(vi) implementation of corrective actions,

''(E) includes standards for timely enrollee access to information and care which at a minimum shall incorporate standards used by the State or professional or accreditation bodies for facilities furnishing perinatal and neonatology care and other forms of specialized medical and surgical care,

''(F) includes standards for the facilities in which patients receive care,

''(G) includes standards for managing and treating medical conditions prevalent among such entity's enrollees eligible for medical assistance under the State plan,

''(H) includes mechanisms to ensure that enrollees eligible for medical assistance under

the State plan receive services for which the entity is responsible under the contract which are consistent with standards established by the applicable professional societies or government agencies,

''(I) includes standards for the availability, maintenance, and review of medical records consistent with generally accepted medical practice,

''(J) provides for dissemination of quality assurance procedures to health care providers under contract with the entity, and

''(K) meets any other requirements prescribed by the Secretary or the State.

''(c) GENERAL REQUIREMENTS FOR PRIMARY CARE CASE MANAGEMENT PROGRAMS.—A primary care case management program implemented by a State under this section shall—

''(1) provide that each primary care case management entity participating in such program has a written contract with the State agency,

''(2) include methods for selection and monitoring of participating primary care case management entities to ensure—

''(A) that the geographic locations, hours of operation, patient to staff ratio, and other relevant characteristics of such entities are sufficient to afford individuals eligible for medical assistance under the State plan access to such entities that is at least equivalent to the access to health care providers that would be available to such individuals if such individuals were not enrolled with such entity,

''(B) that such entities and their professional personnel are licensed as required by State law and qualified to provide case management services, through methods such as ongoing monitoring of compliance with applicable requirements and providing information and technical assistance, and

''(C) that such entities—

''(i) provide timely and appropriate primary care to such enrollees consistent with standards established by applicable professional societies or governmental agencies, or such other standards prescribed by the Secretary or the State, and

''(ii) where other items and services are determined to be medically necessary,

give timely approval of such items and services and referral to appropriate health care providers,

''(3) provide that no preapproval shall be required for emergency health care items or services, and

''(4) permit individuals eligible for medical assistance under the State plan who have enrolled with a primary care case management entity to terminate such enrollment without cause not later than the beginning of the first calendar month following a full calendar month after the request is made for such termination.

''(d) EXEMPTIONS FROM STATE PLAN REQUIREMENTS.—A State plan may permit or require an individual eligible for medical assistance under such plan to enroll with a risk contracting entity or a primary care case management entity without regard to the requirements set forth in the following paragraphs of section 1902(a):

''(1) Paragraph (1) (concerning statewideness).

''(2) Paragraph (10)(B) (concerning comparability of benefits), to the extent benefits not included in the State plan are provided.

''(3) Paragraph (23) (concerning freedom of choice of provider), except with respect to services

described in section 1905(a)(4)(C) and except as required under subsection (e).

''(e) STATE OPTIONS WITH RESPECT TO ENROLLMENT AND DISENROLLMENT.—

''(1) MANDATORY ENROLLMENT.—A State plan may require an individual eligible for medical assistance under such plan to enroll with a risk contracting entity or a primary care case management entity only if the individual is permitted a choice within a reasonable service area (as defined by the State)—

''(A) between or among 2 or more risk contracting entities,

''(B) among a risk contracting entity and a primary care case management program, or

''(C) among primary care case management entities.

''(2) REENROLLMENT OF INDIVIDUALS WHO REGAIN ELIGIBILITY.—In the case of an individual who—

''(A) in a month is eligible for medical assistance under the State plan and enrolled with a risk contracting entity with a contract under this section,

''(B) in the next month (or next 2 months) is not eligible for such medical assistance, but

''(C) in the succeeding month is again eligible for such benefits,

the State agency (subject to subsection (b)(3)(E)) may enroll the individual for that succeeding month with such entity, if the entity continues to have a contract with the State agency under this subsection.

''(3) DISENROLLMENT.—

''(A) RESTRICTIONS ON DISENROLLMENT WITHOUT CAUSE.—Except as provided in subparagraph (C), a State plan may restrict the period in which individuals enrolled with risk contracting entities described in paragraph (4) may terminate such enrollment without cause to the first month of each period of enrollment (as defined in subparagraph (B)), but only if the State provides notification, at least once during each such enrollment period, to individuals enrolled with such entity of the right to terminate such enrollment and the restriction on the exercise of this right. Such restriction shall not apply to requests for termination of enrollment for cause.

''(B) PERIOD OF ENROLLMENT.—For purposes of this paragraph, the term 'period of enrollment' means—

''(i) a period not to exceed 6 months in duration, or

''(ii) a period not to exceed 1 year in duration, in the case of a State that, on the effective date of this paragraph, had in effect a waiver under section 1115 of requirements under this title under which the State could establish a 1-year minimum period of enrollment with risk contracting entities.

''(4) ENTITIES ELIGIBLE FOR DISENROLLMENT RESTRICTIONS.—A risk contracting entity described in this paragraph is—

''(A) a qualified health maintenance organization as defined in section 1310(d) of the Public Health Service Act,

''(B) an eligible organization with a contract under section 1876,

''(C) an entity that is receiving (and has received during the previous 2 years) a grant of at least $100,000 under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act,

''(D) an entity that—

''(i) received a grant of at least $100,000 under section 329(d)(1)(A) or section 330(d)(1) of the Public Health Service Act in the fiscal year ending June 30, 1976, and has been a grantee under either such section for all periods after that date, and

''(ii) provides to its enrollees, on a prepaid capitation or other risk basis, all of the services described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905(a) (and the services described in section 1905(a)(7), to the extent required by section 1902(a)(10)(D)),

''(E) an entity that is receiving (and has received during the previous 2 years) at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965,

''(F) a nonprofit primary health care entity located in a rural area (as defined by the Appalachian Regional Commission)—

''(i) which received in the fiscal year ending June 30, 1976, at least $100,000

(by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965, and

''(ii) which, for all periods after such date, either has been the recipient of a grant, subgrant, or subcontract under such Act or has provided services on a prepaid capitation or other risk basis under a contract with the State agency initially entered into during a year in which the entity was the recipient of such a grant, subgrant, or subcontract,

''(G) an entity that had contracted with the State agency prior to 1970 for the provision, on a prepaid risk basis, of services (which did not include inpatient hospital services) to individuals eligible for medical assistance under the State plan,

''(H) a program pursuant to an undertaking described in subsection (l)(3) in which at least 25 percent of the membership enrolled on a prepaid basis are individuals who—

''(i) are not insured for benefits under part B of title XVIII or eligible for medical assistance under the State plan, and

''(ii) (in the case of such individuals whose prepayments are made in whole or in part by any government entity) had the opportunity at the time of enrollment in the program to elect other coverage of health care costs that would have been paid in whole or in part by any governmental entity,

''(I) an entity that, on the date of enactment of this provision, had a contract with the State agency under a waiver under section 1115 or 1915(b) and was not subject to a requirement under this title to permit disenrollment without cause, or

''(J) an entity that has a contract with the State agency under a waiver under section 1915(b)(5).

''(f) STATE MONITORING AND EXTERNAL REVIEW.—

''(1) STATE GRIEVANCE PROCEDURE.—A State contracting with a risk contracting entity or a primary care case management entity under this section shall provide for a grievance procedure for enrollees of such entity with at least the following elements:

''(A) a toll-free telephone number for enrollee questions and grievances,

''(B) periodic notification of enrollees of their rights with respect to such entity or program,

''(C) periodic sample reviews of grievances registered with such entity or program or with the State, and

''(D) periodic survey and analysis of enrollee satisfaction with such entity or program, including interviews with individuals who disenroll from the entity or program.

''(2) STATE MONITORING OF QUALITY AND ACCESS.—

''(A) RISK CONTRACTING ENTITIES.—A State contracting with a risk contracting entity under this section shall provide for ongoing monitoring of such entity's compliance with the requirements of subsection (b), including compliance with the requirements of such entity's contract under subsection (b)(3), and shall undertake appropriate followup activities to ensure that any problems identified are rectified and that compliance with the requirements of sub-

section (b) and the requirements of the contract under subsection (b)(3) is maintained.

''(B) PRIMARY CARE CASE MANAGEMENT ENTITIES.—A State electing to implement a primary care case management program shall provide for ongoing monitoring of the program's compliance with the requirements of subsection (c) and shall undertake appropriate followup activities to ensure that any problems identified are rectified and that compliance with subsection (c) is maintained.

''(C) SERVICES.—

''(i) IN GENERAL.—The State shall establish procedures (in addition to those required under subparagraphs (A) and (B)) to ensure that the services listed in clause (ii) are available in a timely manner to an individual enrolled with a risk contracting entity or a primary care case management entity. Where necessary to ensure the timely provision of such services, the State shall arrange for the provision of such services by health care providers other than the risk contracting entity or

the primary care case management entity in which an individual is enrolled.

''(ii) SERVICES LISTED.—The services listed in this clause are:

''(I) prenatal care;

''(II) immunizations;

''(III) lead screening and treatment;

''(IV) prevention, diagnosis and treatment of tuberculosis, sexually transmitted diseases (including HIV infection), and other communicable diseases; and

''(V) such other services as the Secretary may specify.

''(iii) REPORT.—The procedures referred to in clause (i) shall be described in an annual report to the Secretary provided by the State.

''(3) EXTERNAL INDEPENDENT REVIEW.—

''(A) IN GENERAL.—Except as provided in paragraph (4), a State contracting with a risk contracting entity under this section shall provide for an annual external independent review of the quality and timeliness of, and access to,

the items and services specified in such entity's contract with the State agency. Such review shall be conducted by a utilization control and peer review organization with a contract under section 1153 or another organization unaffiliated with the State government or with any risk contracting entity and approved by the Secretary.

''(B) CONTENTS OF REVIEW.—An external independent review conducted under this paragraph shall include the following:

''(i) a review of the entity's medical care, through sampling of medical records or other appropriate methods, for indications of quality of care and inappropriate utilization (including overutilization) and treatment,

''(ii) a review of enrollee inpatient and ambulatory data, through sampling of medical records or other appropriate methods, to determine trends in quality and appropriateness of care,

''(iii) notification of the entity and the State when the review under this paragraph indicates inappropriate care, treat-

ment, or utilization of services (including overutilization), and

''(iv) other activities as prescribed by the Secretary or the State.

''(C) AVAILABILITY.—The results of each external independent review conducted under this paragraph shall be available to the public consistent with the requirements for disclosure of information contained in section 1160.

''(4) DEEMED COMPLIANCE WITH EXTERNAL INDEPENDENT QUALITY OF CARE REVIEW REQUIREMENTS.—

''(A) IN GENERAL.—The Secretary may deem the State to have fulfilled the requirement for independent external review of quality of care with respect to an entity which has been accredited by an organization described in subparagraph (B) and approved by the Secretary.

''(B) ACCREDITING ORGANIZATION.—An accrediting organization described in this subparagraph must—

''(i) exist for the primary purpose of accrediting coordinated care organizations;

''(ii) be governed by a group of individuals representing health care providers,

purchasers, regulators, and consumers (a minority of which shall be representatives of health care providers);

''(iii) have substantial experience in accrediting coordinated care organizations, including an organization's internal quality assurance program;

''(iv) be independent of health care providers or associations of health care providers;

''(v) be a nonprofit organization; and

''(vi) have an accreditation process which meets requirements specified by the Secretary.

''(5) FEDERAL MONITORING RESPONSIBILITIES.—The Secretary shall review the external independent reviews conducted pursuant to paragraph (3) and shall monitor the effectiveness of the State's monitoring and followup activities required under subparagraph (A) of paragraph (2). If the Secretary determines that a State's monitoring and followup activities are not adequate to ensure that the requirements of paragraph (2) are met, the Secretary shall undertake appropriate followup activities to en-

sure that the State improves its monitoring and followup activities.

''(g) TRANSACTIONS WITH PARTIES IN INTEREST.—

''(1) IN GENERAL.—Each risk contracting entity which is not a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) must report to the State and, upon request, to the Secretary, the Inspector General of the Department of Health and Human Services, and the Comptroller General of the United States a description of transactions between the entity and a party in interest (as defined in section 1318(b) of such Act), including the following transactions:

''(A) Any sale or exchange, or leasing of any property between the entity and such a party.

''(B) Any furnishing for consideration of goods, services (including management services), or facilities between the entity and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

''(C) Any lending of money or other extension of credit between the entity and such a party.

The State or the Secretary may require that information reported with respect to a risk contracting entity which controls, or is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the risk contracting entity and such entity.

''(2) AVAILABILITY OF INFORMATION.—Each risk contracting entity shall make the information reported pursuant to paragraph (1) available to its enrollees upon reasonable request.

''(h) REMEDIES FOR FAILURE TO COMPLY.—

''(1) IN GENERAL.—If the Secretary determines that a risk contracting entity or a primary care case management entity—

''(A) fails substantially to provide services required under section 1905(r), when such an entity is required to do so, or provide medically necessary items and services that are required to be provided to an individual enrolled with such an entity, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

''(B) imposes premiums on individuals enrolled with such an entity in excess of the premiums permitted under this title;

''(C) acts to discriminate among individuals in violation of the provision of subsection (b)(3)(D), including expulsion or refusal to reenroll an individual or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this section) by eligible individuals with the entity whose medical condition or history indicates a need for substantial future medical services;

''(D) misrepresents or falsifies information that is furnished—

''(i) to the Secretary or the State under this section; or

''(ii) to an individual or to any other entity under this section; or

''(E) fails to comply with the requirements of section 1876(i)(8),

the Secretary may provide, in addition to any other remedies available under law, for any of the remedies described in paragraph (2).

''(2) ADDITIONAL REMEDIES.—The remedies described in this paragraph are—

''(A) civil money penalties of not more than $25,000 for each determination under paragraph (1), or, with respect to a determination under subparagraph (C) or (D)(i) of such paragraph, of not more than $100,000 for each such determination, plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(C), $15,000 for each individual not enrolled as a result of a practice described in such paragraph, or

''(B) denial of payment to the State for medical assistance furnished by a risk contracting entity or a primary care case management entity under this section for individuals enrolled after the date the Secretary notifies the entity of a determination under paragraph (1) and until the Secretary is satisfied that the basis for

such determination has been corrected and is not likely to recur.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (A) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

''(i) TERMINATION OF CONTRACT BY STATE.—Any State which has a contract with a risk contracting entity or a primary care case management entity may terminate such contract if such entity fails to comply with the terms of such contract or any applicable provision of this section.

''(j) FAIR HEARING.—Nothing in this section shall affect the rights of an individual eligible to receive medical assistance under the State plan to obtain a fair hearing under section 1902(a)(3) or under applicable State law.

''(k) REFERRAL PAYMENTS.—For 1 year following the date on which individuals eligible for medical assistance under the State plan in a service area are required to enroll with a risk contracting entity or a primary care case management entity, Federally qualified health centers and rural health centers located in such service area or providing care to such enrollees, shall receive a fee for educating such enrollees about the availability of services

from the risk contracting entity or primary care case management entity with which such enrollees are enrolled.

''(l) SPECIAL RULES.—

''(1) NONAPPLICABILITY OF CERTAIN PROVISIONS TO CERTAIN RISK CONTRACTING ENTITIES.—In the case of any risk contracting entity which—

''(A)(i) is an individual physician or a physician group practice of less than 50 physicians, and

''(ii) is not described in paragraphs (A) and (B) of subsection (b)(1), and

''(B) is at risk only for the health care items and services directly provided by such entity,

paragraphs (3)(K), (3)(L), (3)(O), (3)(P), and (4) of subsection (b), and paragraph (3) of subsection (f), shall not apply to such entity.

''(2) EXCEPTION FROM DEFINITION OF RISK CONTRACTING ENTITY.—For purposes of this section, the term 'risk contracting entity' shall not include a health insuring organization which was used by a State before April 1, 1986, to administer a portion of the State plan of such State on a statewide basis.

''(3) NEW JERSEY.—The rules under section 1903(m)(6) as in effect on the day before the effective date of this section shall apply in the case of an undertaking by the State of New Jersey (as described in such section 1903(m)(6)).

''(m) CONTINUATION OF CERTAIN COORDINATED CARE PROGRAMS.—The Secretary may provide for the continuation of any coordinated care program operating under section 1115 or 1915 without requiring compliance with any provision of this section which conflicts with the continuation of such program and without requiring any additional waivers under such sections 1115 and 1915 if the program has been successful in assuring quality and containing costs (as determined by the Secretary) and is likely to continue to be successful in the future.

''(n) GUIDELINES AND MODEL CONTRACT.—

''(1) GUIDELINES ON SOLVENCY.—At the earliest practicable time after the date of enactment of this section, the Secretary shall issue guidelines concerning solvency standards for risk contracting entities and subcontractors of such risk contracting entities. Such guidelines shall take into account characteristics that may differ among risk contracting entities including whether such an entity is at risk for inpatient hospital services.

''(2) GUIDELINES ON MARKETING.—At the earliest practicable time after the date of enactment of this section, the Secretary shall issue guidelines concerning—

''(A) marketing undertaken by any risk contracting entity or any primary care case management program to individuals eligible for medical assistance under the State plan, and

''(B) information that must be provided by States or any such entity to individuals eligible for medical assistance under the State plan with respect to—

''(i) the options and rights of such individuals to enroll with, and disenroll from, any such entity, as provided in this section, and

''(ii) the availability of services from any such entity (including a list of services for which such entity is responsible or must approve and information on how to obtain services for which such entity is not responsible).

In developing the guidelines under this paragraph, the Secretary shall address the special circumstances of children with special health care needs (as defined

in subsection (e)(1)(B)(ii)) and other individuals with special health care needs.

''(3) MODEL CONTRACT.—The Secretary shall develop a model contract to reflect the requirements of subsection (b)(3) and such other requirements as the Secretary determines appropriate.''

(b) WAIVERS FROM REQUIREMENTS ON COORDINATED CARE PROGRAMS.—Section 1915(b) (42 U.S.C. 1396n) is amended—

(1) in the matter preceding paragraph (1), by striking ''as may be necessary'' and inserting '', and section 1931 as may be necessary'';

(2) in paragraph (1), by striking ''a primary care case management system or'';

(3) by striking ''and'' at the end of paragraph (3);

(4) by striking the period at the end of paragraph (4) and inserting '', and''; and

(5) by inserting after paragraph (4) the following new paragraph:

''(5) to permit a risk contracting entity (as defined in section 1931(a)(3)) to restrict the period in which individuals enrolled with such entity may terminate such enrollment without cause in accordance with section 1931(e)(3)(A).''.

(c) STATE OPTION TO GUARANTEE MEDICAID ELIGIBILITY.—Section 1902(e)(2) (42 U.S.C. 1396a(e)(2)) is amended—

(1) in subparagraph (A), by striking all that precedes ''(but for this paragraph)'' and inserting ''In the case of an individual who is enrolled—

''(i) with a qualified health maintenance organization (as defined in title XIII of the Public Health Service Act) or with a risk contracting entity (as defined in section 1931(a)(3)), or

''(ii) with any risk contracting entity (as defined in section 1931(a)(3)) in a State that, on the effective date of this provision, had in effect a waiver under section 1115 of requirements under this title under which the State could extend eligibility for medical assistance for enrollees of such entity, or

''(iii) with an eligible organization with a contract under section 1876,

and who would'',

(2) in subparagraph (B), by striking ''organization or'' each place it appears, and

(3) by adding at the end the following new subparagraph:

''(C) The State plan may provide, notwithstanding any other provision of this title, that an individual shall be deemed to continue to be eligible for benefits under this title until the end of the month following the month in which such individual would (but for this paragraph) lose such eligibility because of excess income and resources, if the individual is enrolled with a risk contracting entity or primary care case management entity (as those terms are defined in section 1931(a)).''.

(d) ENHANCED MATCH RELATED TO QUALITY REVIEW.—Section 1903(a)(3)(C) (42 U.S.C. 1396b(a)(3)(C)) is amended—

(1) by striking ''organization or by'' and inserting ''organization, by''; and

(2) by striking ''section 1152, as determined by the Secretary,'' and inserting ''section 1152, as determined by the Secretary, or by another organization approved by the Secretary which is unaffiliated with the State government or with any risk contracting entity (as defined in section 1931(a)(3)),''.

(e) CONFORMING AMENDMENTS.—

(1) Section 1128(b)(6)(C)(i) (42 U.S.C. 1320a–7(b)(6)(C)(i)) is amended by striking ''health main-

tenance organization'' and inserting ''risk contracting entity''.

(2) Section 1902(a)(23) (42 U.S.C. 1396a(a)(23)) is amended by striking ''primary care-case management system (described in section 1915(b)(1)), a health maintenance organization,'' and inserting ''primary care case management program (as defined in section 1931(a)(1)), a risk contracting entity (as defined in section 1931(a)(3)),''.

(3) Section 1902(a)(30)(C) (42 U.S.C. 1396a(a)(30)(C)) is amended by striking ''use a utilization'' and all that follows through ''with the results'' and inserting ''provide for independent review and quality assurance of entities with contracts under section 1931, in accordance with subsection (f) of such section 1931, with the results''.

(4) Section 1902(a)(57) (42 U.S.C. 1396a(a)(57)) is amended by striking ''or health maintenance organization (as defined in section 1903(m)(1)(A))'' and inserting ''risk contracting entity, or primary care case management entity (as defined in section 1931(a))''.

(5) Section 1902(a) (42 U.S.C. 1396a), as amended by sections 121, 201(a), 851, 854, and 855, is amended—

(A) by striking ''and'' at the end of paragraph (66);

(B) by striking the period at the end of paragraph (67) and inserting ''; and''; and

(C) by adding at the end the following new paragraphs:

''(68) at State option, provide for a primary care case management program in accordance with section 1931; and

''(69) at State option, provide for a program under which the State contracts with risk contracting entities in accordance with section 1931.''.

(6) Section 1902(p)(2) (42 U.S.C. 1396a(p)(2)) is amended by striking ''health maintenance organization (as defined in section 1903(m))'' and inserting ''risk contracting entity (as defined in section 1931(a)(3))''.

(7) Section 1902(w) (42 U.S.C. 1396a(w)) is amended—

(A) in paragraph (1), by striking ''section 1903(m)(1)(A)'' and inserting ''section 1931(a)(3)'', and

(B) in paragraph (2)(E)—

(i) by striking ''health maintenance organization'' and inserting ''risk contracting entity'', and

(ii) by striking ''organization'' and inserting ''entity''.

(8) Section 1903(k) (42 U.S.C. 1396b(k)) is amended by striking ''health maintenance organization which meets the requirements of subsection (m) of this section'' and inserting ''risk contracting entity which meets the requirements of section 1931''.

(9) Section 1903(w)(7)(A)(viii) (42 U.S.C. 1396b(w)(7)(A)(viii)) is amended by striking ''health maintenance organizations (and other organizations with contracts under section 1903(m))'' and inserting ''risk contracting entities with contracts under section 1931''.

(10) Section 1905(a) (42 U.S.C. 1396d(a)) is amended, in the matter preceding clause (i), by inserting ''(which may be on a prepaid capitation or other risk basis)'' after ''payment''.

(11) Section 1916(b)(2)(D) (42 U.S.C. 1396o(b)(2)(D)) is amended by striking ''health maintenance organization (as defined in section 1903(m))'' and inserting ''risk contracting entity (as defined in section 1931(a)(3))''.

(12) Section 1925(b)(4)(D)(iv) (42 U.S.C. 1396r–6(b)(4)(D)(iv)) is amended—

(A) in the heading, by striking ''**HMO**'' and inserting ''**RISK CONTRACTING ENTITY**'',

(B) by striking ''health maintenance organization (as defined in section 1903(m)(1)(A))'' and inserting ''risk contracting entity (as defined in section 1931(a)(3)'', and

(C) by striking ''health maintenance organization in accordance with section 1903(m)'' and inserting ''risk contracting entity in accordance with section 1931''.

(13) Paragraphs (1) and (2) of section 1926(a) (42 U.S.C. 1396r–7(a)) are each amended by striking ''health maintenance organizations under section 1903(m)'' and inserting ''risk contracting entities under section 1931''.

(13) Section 1927(j)(1) is amended by striking ''* * * Health Maintenance Organizations, including those organizations that contract under section 1903(m)'' and inserting ''risk contracting entities (as defined in section 1931(a)(3))''.

(f) EFFECTIVE DATE.—The amendments made by this section shall become effective with respect to calendar quarters beginning on or after January 1, 1995.

PART III—LONG-TERM CARE PROVISIONS

SEC. 871. STATE OPTION TO PROVIDE HOME OR COMMUNITY BASED CARE SERVICES.

(a) PROVISION AS OPTIONAL SERVICE.—Section 1905(a) (42 U.S.C. 1396d(a)) is amended—

(1) by striking ''and'' at the end of paragraph (24);

(2) by redesignating paragraph (25) as paragraph (26); and

(3) by inserting after paragraph (24) the following new paragraph:

''(25) home or community based services (as defined in section 1905(t)).''.

(b) DEFINITION.—Section 1905 (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

''(t) The term 'home or community based services' means services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals who require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded, the cost of which could be reimbursed under the State plan. For purposes of this subsection, the term 'room and board' shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and

food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.''.

(c) CONFORMING AMENDMENTS.—(1) Section 1902(a)(10)(C)(iv) (42 U.S.C. 1396a(a)(10)(C)(iv)) is amended by striking ''through (24)'' and inserting ''through (25)''.

(2) Section 1902(j) (42 U.S.C. 1396a(j)) is amended by striking ''through (25)'' and inserting ''through (26)''.

SEC. 872. ELIMINATION OF RULE REGARDING AVAILABILITY OF BEDS IN CERTAIN INSTITUTIONS.

(a) IN GENERAL.—The first sentence of section 1915(c)(1) (42 U.S.C. 1396n(c)(1)) is amended by inserting the following before the end period: ''(at the option of the State, such determination may be made without regard to the availability of beds in such a hospital, nursing facility, or intermediate care facility for the mentally retarded located in the State)''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall be effective with respect to waivers granted or renewed on or after January 1, 1995.

SEC. 873. CERTAIN DEMONSTRATION PROJECTS PERMITTED UNDER THE MEDICAID PROGRAM.

(a) IN GENERAL.—Section 1917(b) of the Social Security Act (42 U.S.C. 1396p(b)) is amended—

(1) in paragraph (1), by striking subparagraph (C);

(2) in paragraph (3), by striking ''(other than paragraph (1)(C))''; and

(3) in paragraph (4)(B), by striking ''(and shall include, in the case of an individual to whom paragraph (1)(C)(i) applies)''.

(b) EFFECTIVE DATE.—Section 1917(b) of the Social Security Act (42 U.S.C. 1396p(b)) shall be applied and administered as if the provisions stricken by paragraph (1) had not been enacted.

SEC. 874. ELIMINATION OF REQUIREMENT OF PRIOR INSTITUTIONALIZATION WITH RESPECT TO HABILITATION SERVICES FURNISHED UNDER A WAIVER FOR HOME OR COMMUNITY-BASED SERVICES.

(a) IN GENERAL.—Section 1915(c)(5) (42 U.S.C. 1396n(c)(5)) is amended in the matter preceding subparagraph (A) by striking '', with respect to individuals who receive such services after discharge from a nursing facility or intermediate care facility for the mentally retarded''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1995.

SEC. 875. RELIEF FROM THIRD PARTY LIABILITY REQUIREMENTS WHEN COST-EFFECTIVE.

(a) IN GENERAL.—Section 1902(a)(25)(B) (42 U.S.C. 1396a(a)(25)(B)) is amended to read as follows—

''(B) that in any case where such a legal liability is found to exist after medical assistance has been made available, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability, unless—

''(i) the amount of reimbursement the State can reasonably expect to recover for medical assistance furnished to an individual does not exceed the costs of such recovery, or

''(ii) with respect to case management services (as defined in section 1915(g)(2)), the State demonstrates to the satisfaction of the Secretary that it is not cost-effective in the aggregate to seek such recovery with respect to such services furnished to individuals covered under the State plan, using methods specified by the Secretary which may include a dem-

onstration that such services are not generally covered by health insurers in the State;''.

(b) EFFECTIVE DATE.—The amendments made by this section shall become effective on January 1, 1995.

SEC. 876. STATE EXPENDITURES FOR MEDICAL ASSISTANCE WITH RESPECT TO HOME AND COMMUNITY-BASED SERVICES PROVIDED UNDER A WAIVER.

(a) IN GENERAL.—Section 1915(d)(5)(B) (42 U.S.C. 1396n(d)(5)(B)) is amended—

(1) in clause (i), by striking ''times the number of years'' and inserting ''compounded annually for years'';

(2) in clause (ii), by striking ''times the number of years'' and inserting ''compounded annually for years''; and

(3) in clause (iv), by striking ''December 22, 1987'' and inserting ''the date of the enactment of the Omnibus Budget Reconciliation Act of 1986''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall be effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987.

SEC. 877. EXTENSION AND CONSOLIDATION OF FRAIL ELDERLY DEMONSTRATION PROJECT WAIVERS.

(a) ELIMINATION OF LIMIT ON NUMBER OF WAIVERS.—

(1) IN GENERAL.—Section 9412(b)(1) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking ''not more than 15''.

(2) TRANSITION.—The Secretary of Health and Human Services shall grant waivers under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 to not more than—

(A) 50 organizations before July 1, 1995, or

(B) 75 organizations before July 1, 1996.

(b) INDEFINITE EXTENSION OF PARTICIPATION AND STATUS AS PROVIDERS.—Section 9412(b)(2) of the Omnibus Budget Reconciliation Act of 1986 is amended—

(1) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''this paragraph'',

(2) in subparagraph (A), by adding at the end the following: ''Except as otherwise provided by law or regulation, such terms and conditions, with respect to an organization, shall be substantially equivalent to the terms and conditions provided under the Protocol for the Program of All-inclusive Care for the Elderly (PACE), as published by On Lok, Inc.

(and as recognized by the Health Care Financing Administration) as of June 30, 1994, and made generally available.'';

(2) in subparagraph (C), by striking ''may extend'' and inserting ''shall extend for an indefinite period''; and

(3) by adding at the end the following:

''(D) Upon successful completion of the initial period of the waiver under this subsection, an organization shall be afforded regular provider status under titles XVIII and XIX of the Social Security Act in accordance with appropriate regulations to be promulgated by the Secretary. This subparagraph shall apply to organizations operating under a waiver on or after July 1, 1997.

''(E) The provisions of this paragraph also shall apply to the organization under the On Lok waiver described in subparagraph (A).

''(F) Organizations under this paragraph shall ordinarily be reimbursed on a capitation basis. The organizations may provide additional services as may be deemed appropriate by the organizations without regard to whether such services are specifically reimbursable through capitation payments.''.

(c) TREATMENT OF APPLICATIONS.—Section 9412(b)(1) of such Act is amended by adding at the end

the following: ''An appropriately completed application for a waiver under this subsection is deemed approved unless the Secretary specifically disapproves it in writing within 90 days of the date of its filing (or, if the Secretary requests reasonable and substantial additional information within such 90 day period, within 90 days of the date of providing such additional information). The Secretary shall have sole authority to approve or disapprove the initial and subsequent eligibility of an organization for a waiver and shall make such determinations in a timely manner.''.

(d) PROMOTION OF ADDITIONAL APPLICATIONS.—Section 9412(b) of such Act is amended by adding at the end the following:

''(5) The Secretary shall institute an organized effort to promote the development of organizations under this subsection.''.

(e) PROVISION OF ADDITIONAL SERVICES.—Section 9412(b) of such Act, as amended by subsection (d), is further amended by adding at the end the following:

''(6) Nothing in this subsection shall prevent an organization with a waiver under this subsection from developing and providing appropriate services to frail populations that may not be elderly, except where the Secretary finds that such an extension im-

pair the ability of the organization to provide services required under the waiver.''.

SEC. 878. CERTAIN IMPROVEMENTS IN MEDICAID CASE MANAGEMENT SERVICES AND HOME AND COMMUNITY-BASED WAIVERS.

(a) IN GENERAL.—Section 1902(a) (42 U.S.C. 1396a) is amended—

(1) in paragraph (23), by inserting ''(including case management services under subsections (c), (d), and (g) of such section)'' after ''in section 1915''; and

(2) in paragraph (32)—

(A) by striking the period at the end of subparagraph (C) and inserting ''; and''; and

(B) by adding at the end the following new subparagraph:

''(D) in the case of services arranged through the case management agency under subsections (c), (d), or (g) of section 1915, payments made by the case management agency to providers of services shall be permitted provided that—

''(i) the case management entity is a nonprofit entity;

''(ii) the case management entity maintains a clear system of records demonstrating conformity between payments made and services required under the individual's plan of care; and

''(iii) the entity makes assurances satisfactory to the State that providers paid by the entity, for covered services to individuals eligible under this title, are eligible for payments under the provisions of this title;''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to payments for medical assistance for calendar quarters beginning on or after January 1, 1995.

PART IV—OTHER PROVISIONS

SEC. 881. AMENDMENTS TO PROVISIONS REQUIRING STATES TO MAKE DSH PAYMENT ADJUSTMENTS.

(a) IN GENERAL.—

(1) ADJUSTMENT TO NATIONAL DSH PAYMENT LIMIT.—Section 1923(f)(1)(B) (42 U.S.C. 1396r–4(f)(1)(B)) is amended by striking ''12 percent'' and inserting ''9 percent''.

(2) ADJUSTMENTS TO STATE ALLOTMENT LIMITS.—Section 1923(f)(2)(B)(i) (42 U.S.C. 1396r–4(f)(2)(B)(i)) is amended by striking ''12 percent'' and inserting ''9 percent''.

(3) ADJUSTMENT RELATING TO HIGH DSH STATES.—

(A) IN GENERAL.—Section 1923(f)(2)(B)(i) (42 U.S.C. 1396r–4(f)(2)(B)(i)) is amended by striking ''the State DSH allotment shall equal the State based allotment'' and inserting ''the State DSH allotment shall be an amount equal to the State based allotment less 25 percent of such allotment''.

(4) EFFECTIVE DATE.—The amendments made by this section shall be effective for calendar quarters beginning on or after January 1, 1997.

SEC. 882. RECOMMENDATIONS BY THE SECRETARY ON A PHASED-IN ELIMINATION OF MEDICAID HOSPITAL DISPROPORTIONATE SHARE ADJUSTMENT PAYMENTS.

Not later than January 1, 2000, the Secretary shall submit recommendations to Congress on a phased-in elimination of the hospital disproportionate share adjust-

ment payments under section 1923 of the Social Security Act.

SEC. 883. REVISION OF FEDERAL MEDICAL ASSISTANCE PERCENTAGE FOR CERTAIN STATES.

(a) IN GENERAL.—Section 1905(b) (42 U.S.C. 1396d(b)) is amended—

(1) by redesignating clauses (1) and (2) as clauses (2) and (3) and by inserting after ''except that'' the following: ''(1) for Alaska, the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the adjusted per capita income of such State bears to the square of the per capita income of the United States;''; and

(2) by inserting after the first sentence the following: ''The 'adjusted per capita income' for Alaska shall be determined by dividing the State 3-year average per capita income by 1.25.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall become effective on October 1, 1995.

SEC. 884. CRITERIA FOR DETERMINING THE AMOUNT OF DISALLOWANCES.

(a) IN GENERAL.—

(1) CRITERIA FOR INITIAL DETERMINATIONS.—Section 1903 (42 U.S.C. 1396b) is amended by adding at the end the following new subsection:

''(x) If the Secretary determines that a disallowance of Federal financial participation should be made under this title with respect to any item or class of items, the Secretary shall, in making a determination with respect to the amount of such disallowance, take into account (to the extent the State makes a showing) factors which shall include—

''(1) whether the amount of the disallowance is reasonably related to the act or omission by the State which is the basis for the disallowance; and

''(2) whether the act or omission by the State which is the basis for the disallowance was based on a reasonable interpretation of Federal statutes, Federal regulations, or any written guidance provided by the Secretary.''.

(2) CRITERIA FOR REDETERMINATIONS.—Section 1116(d) (42 U.S.C. 1316(d)) is amended—

(A) by striking ''(d)'' and inserting ''(d)(1)''; and

(B) by adding at the end the following new paragraph:

''(2) In conducting any reconsideration of a disallowance of Federal financial participation by the Secretary under title XIX, the Departmental Appeals Board of the Department of Health and Human Services (or another entity designated by the Secretary), shall, if such Board or entity upholds the basis for the disallowance, determine whether the amount of the disallowance properly takes into account the factors listed in section 1903(x). If the amount of the disallowance does not properly take into account such factors, the Board shall adjust such amount in accordance with such factors.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to disallowances made after the date of the enactment of this Act and shall take effect without regard to the promulgation of implementing regulations.

SEC. 885. TECHNICAL CORRECTIONS RELATING TO SECTION 4752 OF OBRA–1990 (PHYSICIANS' SERVICES).

(a) Paragraph (59) of section 1902(a) (42 U.S.C. 1396a(a)), as added by section 4752(c)(1)(C) of the Omnibus Budget Reconciliation Act of 1990 and as redesignated by section 13623(a)(6) of the Omnibus Budget Reconciliation Act of 1993, is amended by striking ''subsection (v)'' and inserting ''subsection (x)''.

(b) Section 1903(i)(12) (42 U.S.C. 1396b(i)(12)), as inserted by section 4752(e) of the Omnibus Budget Reconciliation Act of 1990 and as redesignated by section 13631(c)(3) of the Omnibus Budget Reconciliation Act of 1993, is amended—

(1) by amending clause (i) of subparagraph (A) to read as follows:

''(i) is certified in family practice or pediatrics by the medical specialty board recognized by the American Board of Medical Specialties for family practice or pediatrics or is certified in general practice or pediatrics by the medical specialty board recognized by the American Osteopathic Association,'';

(2) by amending clause (i) of subparagraph (B) to read as follows:

''(i) is certified in family practice or obstetrics by the medical specialty board recognized by the American Board of Medical Specialties for family practice or obstetrics or is certified in general practice or obstetrics by the Medical Specialty Board recognized by the American Osteopathic Association,''; and

(3) in subparagraphs (A) and (B)—

(A) by striking ''or'' at the end of clause (v);

(B) by redesignating clause (vi) as clause (vii); and

(C) by inserting after clause (v) the following new clause:

''(vi) delivers such services in the emergency department of a hospital participating in the State plan approved under this title, or''.

TITLE IX—DEPARTMENT OF VETERANS AFFAIRS

SEC. 901. SHORT TITLE.

This title may be cited as the ''Veterans Health Care Administrative Flexibility Act of 1994''.

SEC. 902. PURPOSE.

The purpose of this title is to facilitate the provision of health care services by the Department of Veterans Affairs by—

(1) granting the Department sufficient flexibility to respond rapidly and effectively to local marketing and regulatory conditions (including health care reform legislation that might be enacted by the States); and

(2) granting the Department the authority and resources to facilitate the timely acquisition of necessary facilities and services at a local level.

SEC. 903. HEALTH CARE REFORM BY THE STATES.

(a) INTENT OF CONGRESS.—It is the intent of Congress that the Department of Veterans Affairs health care facilities shall participate as health care providers recognized under health care reform legislation enacted by the several States. To the extent practicable, the Secretary of Veterans Affairs shall provide health care services in a State enacting such reform legislation as if such facilities were providers under such legislation of that State.

(b) PROHIBITION.—Notwithstanding any other provision of law, a State that enacts health care reform legislation may not prohibit the participation of the Department as a health care provider under such legislation unless the chief executive officer of the State certifies to the Secretary that—

(1) the benefits to be provided by the Department do not meet the requirements for quality of benefits established by the reform legislation; or

(2) the location of Department facilities (including facilities providing services by contract or agreement with the Secretary) in the State is such that the proximity of eligible persons to such facilities

does not meet the requirements so established for such proximity.

SEC. 904. AUTHORITY TO EXEMPT DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE FACILITIES FROM CERTAIN PROVISIONS OF LAW.

(a) IN GENERAL.—Chapter 73 of title 38, United States Code, is amended—

(1) by redesignating subchapter IV as subchapter V; and

(2) by inserting after subchapter III the following new subchapter IV:

''SUBCHAPTER IV—EXEMPTIONS

''§ 7341. Designation of exempt facilities

''In order to facilitate the provision of health care services by the Department in a manner that is responsive to local market and regulatory conditions, the Secretary may designate health care facilities of the Department which shall be exempt from provisions of law as specified in this subchapter.

''§ 7342. Contracts and agreements

''(a) If designated by the Secretary under section 7341 of this title to be exempt from provisions of law as specified in this subchapter, a health care facility of the Department may enter into contracts and agreements for the provision of health care services and contracts and

agreements for other services (including procurement of equipment, maintenance and repair services, and other services related to the provision of health care services) as specified in this section.

''(b) Contracts and agreements (including leases) under subsection (a) shall not be subject to the following provisions of law:

''(1) Section 8110(c) of this title, relating to contracting of services at Department health care facilities.

''(2) Section 8122(a)(1) of this title, relating to the lease of Department property.

''(3) Section 8125 of this title, relating to local contracts for the procurement of health care items.

''(4) Section 702 of title 5, relating to the right of review of agency wrongs by the courts of the United States.

''(5) Sections 1346(a)(2) and 1491 of title 28, relating to the jurisdiction of the district courts of the United States and the United States Court of Federal Claims, respectively, for the actions enumerated in such sections.

''(6) Subchapter V of chapter 35 of title 31, relating to the adjudication of protests of violations of procurement statutes and regulations.

''(7) Sections 3526 and 3702 of such title, relating to the settlement of accounts and claims, respectively, of the United States.

''(8) Subsection (b)(7), (e), (f), (g), and (h) of section 8 of the Small Business Act (15 U.S.C. 637(b)(7), (e), (f), (g), and (h)), relating to requirements with respect to small businesses for contracts for property and services.

''(9) The provisions of law assembled for purposes of codification of the United States Code as section 471 through 544 of title 40 that relate to the authority of the Administrator of General Services over the lease and disposal of Federal Government property.

''(10) The provisions of the Office of Federal Procurement Policy Act (41 U.S.C. 401 et seq.), relating to the procurement of property and services by the Federal Government.

''(11) Chapter 3 of the Federal Property and Administrative Services Act of 1949 (41 U.S.C. 251 et seq.), relating to the procurement of property and services by the Federal Government.

''(12) Office of Management and Budget Circular A–76.

''(c)(1) Notwithstanding any other provision of law, contracts and agreements for the provision of health care services under this section may include contracts and agreements with insurers, health care providers, or other individuals or entities that provide health care services.

''(2) Contracts and agreements under this subsection may be entered into without prior review by the Central Office of the Department.

''(d)(1) A contract or agreement under this section for services other than the services referred to in subsection (c) (including a contract or agreement for procurement of equipment, maintenance and repair services, and other services related to the provision of health care services) shall not be subject to prior review by the Central Office of the Department if the amount of the contract or agreement is less than $250,000.

''(2) The Central Office may conduct a prior review of a contract or agreement referred to in paragraph (1) if the amount of the contract or agreement is $250,000 or greater.

''§ 7343. Department personnel

''Notwithstanding any other provision of law, with respect to facilities designated by the Secretary under section 7341 of this title to be exempt from provisions of law as specified in this subchapter, the Secretary may—

''(1) appoint health care personnel to positions in that facility in accordance with such qualifications for such positions as the Secretary may establish; and

''(2) promote and advance personnel serving in such positions in accordance with such qualifications as the Secretary may establish.

''§ 7344. Funding

''(a) To the extent authorized by current law, the Secretary may continue to collect funds from third party payers to defray the costs of providing health care services to veterans.

''(b) As a repository for funds referred to in subsection (a), there is established in the Treasury a fund to be known as the Department of Veterans Affairs Health Care Reform Fund (hereafter referred to in this section as the 'Fund').

''(c)(1) Notwithstanding any other provision of law, amounts shall be deposited in the Fund as follows:

''(A) Amounts collected as referred to in subsection (a).

''(B) Amounts made available based on a determination under subsection (d).

''(C) Amounts transferred to the Fund under subsection (e).

''(D) Such other amounts as the Secretary determines to be necessary.

''(E) Such other amounts as may be appropriated to the Fund.

''(2) The Secretary shall make available amounts under subparagraphs (B) and (D) of paragraph (1) from amounts appropriated to the Department of Veterans Affairs for the provision of health care services.

''(3) The Secretary shall establish and maintain a separate account under the Fund for each health care facility designated under section 7341 of this title as exempt from the provisions of law as specified in this subchapter. Any deposits and expenditures with respect to a designated facility shall be made to or from the account established and maintained with respect to that facility.

''(d)(1) For each year of the operation of a designated facility, the Secretary shall deposit in the account of the Fund for the facility an amount (as determined by the Secretary) equal to the amount that would otherwise be made available to the facility for the payment of the cost of health care services by the facility in that year. The Secretary shall deposit such amount at the beginning of such year.

''(2) The costs referred to in paragraph (1) shall not include costs relating to the provision by the Secretary of the following services:

''(A) Services relating to post-traumatic stress disorder.

''(B) Services relating to spinal-cord injuries.

''(C) Services relating to substance abuse.

''(D) Services relating to the rehabilitation of blind veterans.

''(e) Funds deposited in the Medical-Care Cost Recovery Fund established under section 1729(g) of this title during any fiscal year in an amount in excess of the Congressional Budget Office baseline (as of the date of the enactment of the Veterans Health Care Administrative Flexibility Act of 1994) for deposits in that fund for that fiscal year shall not be subject to paragraph (4) of section 1710(f), 1712(f), or 1729(g) of this title, as the case may be, but shall be transferred to the Fund. Such transfer for any fiscal year shall be made at any time that the total of amounts so received less amounts estimated to cover the expenses, payments, and costs described in paragraph (3) of section 1729(g) of this title is in excess of the applicable Congressional Budget Office baseline.

''(f) Notwithstanding any other provision of law, the facility director for each facility designated under section

7341 of this title as exempt from the provisions of law as specified in this subchapter shall determine the costs for which amounts in the Fund may be expended in providing health care services at that facility.

"§ 7345. Expenditure authority

''(a)(1) Except as provided in paragraph (2), if designated by the Secretary under section 7341 of this title to be exempt from provisions of law as specified in this subchapter, a health care facility of the Department may expend funds under this section in order to cover the following costs:

''(A) Costs of marketing and advertising health care services.

''(B) Costs of legal services provided to the facility by the General Counsel of the Department relating to this subchapter.

''(C) Costs relating to acquisition (including acquisition of land), construction, repair, or renovation of facilities.

''(2) Costs under this section shall not include costs relating to a major medical facility project or a major medical facility lease as such terms are defined in subparagraphs (A) and (B) of section 8104(a)(3) of this title, respectively.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 is amended by striking out the item relating to the heading for subchapter IV and inserting in lieu thereof the following:

''SUBCHAPTER IV—EXEMPTIONS

''7341. Designation of exempt facilities.
''7342. Contracts and agreements.
''7343. Department personnel.
''7344. Funding.
''7345. Expenditure authority.

''SUBCHAPTER V—RESEARCH CORPORATIONS''.

S 2374 PCS——2

S 2374 PCS——3

S 2374 PCS——4

S 2374 PCS——5

S 2374 PCS——6

S 2374 PCS——7

S 2374 PCS——8

S 2374 PCS——9

S 2374 PCS——10

S 2374 PCS——11

S 2374 PCS——12

S 2374 PCS——13

S 2374 PCS——14

S 2374 PCS——15

S 2374 PCS——16

S 2374 PCS——17

S 2374 PCS——18

S 2374 PCS——19

S 2374 PCS——20

S 2374 PCS——21

S 2374 PCS——22

S 2374 PCS——23

S 2374 PCS——24

S 2374 PCS——25

S 2374 PCS——26

S 2374 PCS——27

S 2374 PCS——28

S 2374 PCS——29

S 2374 PCS——30

S 2374 PCS——31

S 2374 PCS——32

S 2374 PCS——33

S 2374 PCS——34

S 2374 PCS——35

S 2374 PCS——36

S 2374 PCS——37

S 2374 PCS——38

S 2374 PCS——39

S 2374 PCS——40

S 2374 PCS——41